SPIRIT OF ST. LOUIS DENTAL
Dr. Jack E. Wolf, D.M.D.
Dr. Erik J. Grant, D.D.S.
139 Long Road
Chesterfield, MO 63005

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: (_____)_____ E-Mail: _____

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Section B: To The Patient – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form you will consent to our use of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice describes a description of our treatment, payments activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices,. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain those changes. Those changes may apply to any of your protected health information that we maintain.

***A copy of our Notice of Privacy Practices, including any revisions can be obtained at any time by contacting*:**
Spirit Dental 139 Long Road, Chesterfield, MO 63005 (636) 530 -7260 (636) 733 – 9084

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the name and address listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline treatment or continuing treatment if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health care information to carry out treatment, payment activities and health care operations.

SIGNATURE: _____ DATE: _____

If this consent is signed by a personal representative other than the Patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____