Icon Dentistry PA - Robert Bowman, DDS
Consent for Use and Disclosure of Health Information

Patient Consent Today's date_____

Patient Name_____ Date of birth _____

Please read the following statements carefully.

Purpose of consent: By signing this form, you consent to our use and disclosure 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 to sign this consent form. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the use 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 form.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change the terms in our notice, we will issue a revised Notice of Privacy Practices. Changes may apply to any of our protected health information that we maintain. You may request a copy of our Notice of Privacy Practices at any time by contacting:

Icon Dentistry PA
Robert Bowman, DDS
c/o HIPAA Representative
1707 NW St. Lucie West Blvd. #126
Port St. Lucie, FL, 34986
Office: 772-344-3300 Fax: 772-344-3301

Right to revoke: You have the right to revoke this consent at any time by sending your written request to the address above. The revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation. We may decline to treat you or continue treating you if you revoke this consent.

Authorization to release information

I, _____, authorize the following person(s) to have access to my health and financial information covered under the Notice of Privacy Practices.

_____ _____
Designee name Relationship

_____ _____
Designee name Relationship

I have had full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand that by signing this form, I agree to the disclosure of health information to my designees.

_____ _____
Signature Printed Name