

FAMILY DENTISTRY OF KEYPORT

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ Email: _____

Social Security Number: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will 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 whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure 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 and complete this carefully 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 the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact: Family Dentistry of Keyport

Telephone: (732)264-3963 Fax: (732)264-9411

Email: keyportdentistry@gmail.com

Address: 45 Maple Place Keyport, NJ 07735

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 contact the person listed above. Please understand the revocation of this Consent will *not* affect any action we take in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE:

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

Signature: _____

Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to patient: _____