



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____
Address: _____
Telephone: (_____) _____ - _____ E-Mail: _____
Social Security Number: _____ - _____ - _____

SECTION B: INFORMATION TO THE PATIENT

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, healthcare operations and release of photos for educational purposes.

Notice of Privacy Practices: You have the right to read our “Notice of Privacy Practices” before you decide to sign this consent. Our notice provides a detailed description of our treatment, payment activities and our healthcare operations, the uses and disclosures that we may make of your protected health information and of other important matters about your protected health information. A copy of our “Notice of Privacy Practices” is available upon request.

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 change(s). 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 Nicole:

Telephone: (763) 427-1311 _____ Fax: (763) 427-1315 _____
E-Mail: www.moffittrestorativedentistry.com _____
Address: 502 Jefferson Highway N., Champlin, MN 55316 _____

Right to Revoke: You will have the right to revoke this consent at any time by submitting a written notice of your revocation to the contact person named above. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent prior to receiving your revocation. We reserve the right to decline to treat or to discontinue treatment if you revoke this consent.

SIGNATURE

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

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative’s Name: _____
Relationship to Patient: _____