Patterson Family Dentistry, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You are entitled to a copy of this consent after you sign it.

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____

Social Security #: _____

Under the requirements of HIPPA, we are not allowed to give medical/dental information to anyone without the patient's consent. If you wish to have any of your medical/dental/insurance/billing information released to family members or friends, please list the individual(s) below:

Name: _____ Phone #: _____Relationship: _____

Name: _____ Phone #:_____Relationship: _____

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 and healthcare operations.

Note of Privacy Practices: You have the right to read your Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, 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 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, including any revisions of our Notice at any time by contacting:

Dr. Ryan Patterson, D.D.S.

578 Geiger Dr., Ste D Roanoke, IN 46783 (260)672-3347	642 N. Opportunity Dr. Ste 101 Columbia City, IN 46725 (260)248-4858	67470 Fernbrook Rd New Paris, IN 46553 (574)831-4477

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 Contact Person 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 to treat you or continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent 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 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:

Name: _____ Relationship to Patient: _____