Dental Health of Fianna

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Giving Consent

Name: ____

Address: ____

Phone: ______________________ Email: ________________________ Soc. Security #: ________________________

Patient - Read the following statements carefully:

1. 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.

2. 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 description of our treatment, payment activities, and healthcare operations of uses and disclosures we may make of your protected health information and of other important matters about your protected health information. We encourage you to read it carefully prior to 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting Sheila Sams, Office Manager at 479-646-0410 or admin@fortsmithdentist.com. She may also be reached via fax at 479-646-5054 or in office at 9004 Jenny Lind Road, Fort Smith, AR, 72908.

Right to Revoke: You will have the right to revoke this consent at any time by giving us a 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 of this consent before we received your revocation and that we may decline to treat you or continue treating you if you revoke this consent.

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 consent form, I am giving my consent to Dental Health of Fianna's 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 anyone other than the patient, please complete the following:

Personal Representative or Legal Guardian Printed Name: ____

Personal Representative or Legal Guardian Signature: ____

Relationship to Patient: ____

Dental Health of Fianna

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I, ____________________ have reviewed a copy of Dental Health of Fianna's Notice of Privacy Practices.

I authorize Dental Health of Fianna to share my protected health and financial information with the following Individuals (spouse, parents, children, etc.)

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___________________________	_________________________________	________________________
Printed Name	Signature	Date

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This portion is for office use only

We, Dental Health of Fianna attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but the acknowledgment could not be obtained because:

________ Individual refused to sign

________ Communication barriers prohibited obtaining the acknowledgment

________ An emergency situation prevented us from obtaining acknowledgment

________ Other (specify reason) ____

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