JEFFREY M. GREENHILL, D.D.S., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
HIPPA

***SECTION A*: PATIENT GIVING CONSENT**

_____

PATIENT/PARENT/GURDIAN NAME (**PRINT**)

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

Personal Representative's or Parent's Name:_____
(**PRINT**)

Relationship to Patient: _____ Patient Name:_____
(**PRINT**) (**PRINT**)

***SECTION B*: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENS CAREFULLY**

Purpose of Consent: By signing this form, you will consent to 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 disclosures we may make of your protected health information, and of the 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.

Contact Person:_____ Telephone:_____
(**PRINT**)

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this
(**PRINT**)
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.

_____ _____
PATIENT/PARENT/GURDIAN **SIGNATURE** **DATE**

Right 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 to continue to treat you if you revoke this Consent.

Signature: _____ Date: _____ Office Initials: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.