Arlington Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME (Print) _____

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 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 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 written copy of our Notice of Privacy Practices at any time by contacting:
Contact Officer: Kelsey Clark
Telephone: 360-658-7741

Right to Revoke: You 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 prior to your revocation.

I, as the Patient or the Patient's Representative, 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. In addition, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY Y / N SPOUSE / PARTNER ONLY Y/ N OTHER _____ Y/ N

Patient Signature: _____Date: _____
If this Consent is signed by a Personal Representative on behalf of the patient, please complete the following:

Representative's Name: (print) _____ **Relationship to Patient_____**

Representative's Signature:_____ Date:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed Consent in the patient's chart.

*****Acknowledgement of Receipt of Notice of Privacy Practices*****

You may refuse to sign this acknowledgement

Patient's Name: (print) _____Date_____

Patient's Signature: _____

I, (Print signature name, if signing as Representative) _____, have received a copy of

this office's Notice of Privacy Practices. Signature of Representative_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__An emergency situation prevented us from obtaining acknowledgment
__Other (Please specify) _____