HIPAA FORM
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you 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 to sign this consent. Our Notice provides a description of our treatment, payment activities, healthcare operations and of the uses and disclosures we may make of your protected health information.

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 those changes. These changes may apply to any of your protected health information that we maintain. Revised copies of our Privacy Practices are issued to the patient or responsible party upon request.

Right to Revoke: You have the right to revoke this consent at any time by giving us WRITTEN NOTICE of your revocation. This written notice must be submitted in its original form, in person or by mail. *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.*

ACKNOWLEDGEMENT

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 healthcare operations. I hereby Authorize Grayhawk Dental Associates to release or disclose my dental record information to:

Name: _____ Relationship _____

_____ Date: _____
Signature of patient, parent or guardian

*** If this consent is being signed by a personal representative on behalf of the patient, please complete the following (does NOT include parents of minors):**

Personal Representative's Name (please print): _____

Relationship to Patient: _____

REVOCATION OF CONSENT

Please only sign here if you wish to revoke your consent, otherwise leave blank

I hereby revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat, or continue to treat me, after I have revoked my consent.

_____ Date: _____
Signature of patient, parent or guardian