Chesterfield Dentist

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: TO THE PATIENT – PLEASE READ THE FOLOWING 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.

Notice of Privacy Practices:

You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this consent form. Our notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protect health information. A copy of our notice is at our front desk for your review. **We encourage you to read it carefully and completely before 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 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 of our Notice at any time by contacting:

Contact Person: The Office Manager

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 your revocation, and that we will decline to treat you or discontinue treating you if you revoke this Consent.

I, _____have had the full opportunity
(Patient's Name)
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 as described in the **" Notice of Privacy Practices**"

_____ _____
Signature of Patient or Patient Representative Date

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

Relationship to patient: _____

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

11601 Iron Bridge Road, Suite 204 – Chester, VA 23831 – (804) 717-5100