

**PREMIERE DENTISTRY**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**SECTION B: 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 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. At your request, we will gladly give you a copy of our Notice of Privacy Practices to take with you.

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 that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person: Dr. Mark D. Smith (owner)      Telephone: (918)456-2555      Fax: (918)456-2444**

**Address: 1205 E. Ross Bypass, Tahlequah, OK 74464      E-mail: [premieredentistry@yahoo.com](mailto:premieredentistry@yahoo.com)**

**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 we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

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 wish to be contacted in the following manner (check all that apply):

**Home/Cell Telephone** \_\_\_\_\_

OK to leave message with detailed information

Leave message with call back number only

OK to receive/send text messages

**Work Telephone** \_\_\_\_\_

OK to leave message with detailed information

Leave message with call back number only

**Written Communication**

OK to mail to my home address

Email address \_\_\_\_\_

**Other** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

**Personal Representative's Name:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU HAVE SIGNED IT.**