CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____ Social Security Number _____
Phone Number: _____ Email: _____
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 protected health information to carry out treatment, payment activities, and healthcare operations. This includes but is not limited to protected health information submitted to insurance companies and other relevant healthcare providers:

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decided whether to sign this Consent. Our Notices 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 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 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 Notices, at any time by contacting: Contact Information:

HIPPA INFORMATION DEPARTMENT
Susan M. Leoni, DMD, D.ABDSM
725 Skippack Pike, Suite # 125, Blue Bell, PA 19422

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 continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had the 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 options.

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 SIGN IT