William B. DeNamur, D.M.D., P.C.

Acknowledgement of Privacy Practices and Consent for Use and Disclosure of Health Information

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Section A: Patient Giving Consent

Name: ____

Address: ____

Telephone: __________________________ Date of Birth: _____________________________

Section B: To the Patient-please read the following statements carefully.

Purpose of consent: By signing this form, you will consent to our use of disclosure of your protected health information to carry our treatment, payment activities, and healthcare operations.

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 office Contact Person. Please understand that revocation of the 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.

I, _____________________________, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: __________________________________ Date: ______________________________

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative Name: ____

Relationship to Patient: ____

You are entitled to a copy of this consent after you sign it.