

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ Patient Birthdate: _____

Address: _____ Phone: _____

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 also gives us permission to display your "Good Checkup Club" photos on the wall. This gives us permission to leave phone messages to help us provide complete dental care such as confirmations, medication reminders, treatment follow up phone calls, update insurance information etc.

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.

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 to our Notice, at any time by contacting:
John Kupcha, D.D.S. 308 Tuckerton Road Medford, NJ 08055 609-714-2273 Smile@medfordfamilydentalcare.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 to 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 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 operations.

Signature: _____ Date: _____
Patient, Parent or Guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices.

_____	_____	_____
Please Print Patient's Name	Patient, Parent or Guardian Signature	Date

FOR OFFICE USE ONLY

We have attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign Communications barriers prohibited obtaining the acknowledgement An emergency situation prevented us from obtaining acknowledgement Other (Please Specify) _____