Antioch Dental Care
3200 Lone Tree Way, Suite 100
Antioch, CA 94509
925 (754) 2122

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient name:
Patient Address
Patient phone number

PLEASE READ CAREFULLY

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

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, healthcare operations and payment activities, of the uses and disclosures we may make of your private health information and of other important matters about your protected health information. A copy of this notice is available to you, you may have a copy for your own records on request. 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. These changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions at any time by contacting the Office Manager at the office address or phone number, (see top of this page).

Right to Revoke:

You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Office Manager at the office address (see top of this page). Please understand that revocation of this consent which may effect any action we took in reliance of this consent before we received revocation, and that we may decline to treat you or to continue to treat you if you revoke this consent.

I, **(print name)**_____, 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, healthcare operations and payment activities.

Signature_____ **Date**_____

If this consent is signed by a Parent/Guardian of a minor child, or personal representative on behalf of the patient please complete the following

Parent/guardian or personal representative name (print)_____

Relationship to the patient_____

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this form, please ask to speak with the Office manager who is our HIPAA Compliance Officer in person or by telephone.

Signature below is only acknowledgement that you have received this notice of our privacy practices.

Print name_____

Signature_____ **Date**_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT DOCUMENT AFTER YOU SIGN IT, PLEASE ASK IF YOU WOULD LIKE TO RECEIVE A COPY FOR YOUR OWN RECORDS.