Patient's Name: _________________________________ Date of Birth: __________________________________

Acknowledgement of Receipt of Notice of Privacy Practices Consent to Use and Disclose of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information many be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payments, or supporting the day-to-day health care operations of this practice.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use of disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Authorization to Share My Protected Health Information with the Following

I wish to place the following exceptions on disclosure of my Protected Health Information. I authorize Valley Dental Works and staff to opening speak to the following person/persons regarding my Protected Health Information:

Name: Relationship:

____

____

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information

____

Patient or Guardian Signature Date

____

Minor Signature if 14 to 17 years of age Date

Print Full Name: ____________________________________/____

Name Name

Internal Use

Received by: ____