Joshua Hardwick, DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A:PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ E-Mail_____

Social Security Number:_____

SECTION B:TO THE PATIENT-PLEASE READ THE FOLLOWING STATE,MENTS 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare
operations, of the use and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice of Privacy Practices is available at the front desk. We encourage you to read over 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 practice, 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 we maintain.

You may obtain a copy of out Notice of Privacy Practices, including any revisions of your notice, at any time, by contacting:

Aynor Family Dental
251 9th Ave ext.
Aynor, South Carolina 29511

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 Contact Person listed above. Please understand that the revocation of this Consent\Will NOT affect any action we took in reliance on this Consent before we received you revocation, and that we may decline to treat you or to continue to treat 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 giving my consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities,
and healthcare operations.

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's
Name:_____

Relationship to
Patient:_____

YOU ARE, ENTITLED TO A COPY OF THIS CONSENT AFTE,R YOU SIGN IT.
A copy of this completed consent is to be included in the patient's chart.