

America's Family Dental

Josh W. Gosnell, D.D.S. • Robert M. Turner, D.D.S.
616 West Main Street • Tomball, Texas 77375
(281) 290-8000

HIPPA PRIVACY FORM 3

Consent for Use and Disclosure of Health Information

Purpose: In cases where America's Family Dental has directed not to rely on acknowledgments as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

SECTION A: PATIENT GIVING CONSENT

Name (printed): _____

Guardian / Legal Representative: _____
(if patient is minor or unable to sign)

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING 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 whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations; and of the used, disclosures and other important matters about your protected health information. A copy of our Notice is available at the front desk. Upon your request, we will provide a copy for your review, and you are welcome to keep it. 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 for our Notice, at any time by contacting our office. Phone: (281) 290-8000, Fax: (281) 516-2397, E-Mail: info@americasfamilydental.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 office. Please understand that revocation of this 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. **At your request, we will provide a revocation of consent for you to sign.**

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: _____

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

Personal Representative's Name: _____ Relationship: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT ONCE YOU HAVE SIGNED IT.