



HIPAA Consent For Use and Disclosure of Health Information

Section A: PATIENT GIVING CONSENT

Name: _____ SS#: _____

Address: _____

Phone #: _____ Email: _____

Section B: TO THE PATIENT - 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 your 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, 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 of our Notice, at any time by contacting:

Contact Person - Business Manager, Quakertown Family Dental Center
280 Trumbauersville Road
Quakertown, PA 18951

Phone # 215-536-1562 Fax# 215-538-9694 Email qtfamilydental@gmail.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 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.

May we phone, email, or send a text to you to confirm appointments? **YES NO**

May we discuss your Dental/Medical condition with any member of your family? **YES NO

**If YES, please name the members allowed:

Signature: _____ Date: _____

Witness: _____ Date: _____