Affordable Family Dental

Section A: patient giving consent

Name: ______________________________ Phone #: ___________________
Address: ____
Social Security #: _________________________

Section B: Please read 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 health care operations.
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. 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.

Signature

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, such as a parent or guardian signs this consent, complete the following:

Personal representative's name____
Relationship to patient_______________________________________

Revocation of consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and health care operations.
I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my consent

Signature _________________________________Date__________________________