



i-donticsSM



Consent for Use and Disclosure of Health Information

Name: _____

Address: _____

Phone: (_____) _____ Date of Birth: ____ - ____ - ____

Referring Dr. _____ Address: _____

Send to Dr. _____ Address: _____

Please read the following statements carefully before signing this form

Purpose of consent: By signing this form, you 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, 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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

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: _____

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.

PRINT NAME:

I, _____, have received and 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 use and disclosure my protected health information to carry out treatment, payment activities, and healthcare with *i-dontics*, LLC.

Signature: _____ **Date:** _____

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

Personal Representative's Name (print): _____ Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
THIS CONSENT WILL BE INCLUDED AS A PERMANENT DOCUMENT
IN OUR RECORDS LOCATED AT THIS OFFICE.**