Preserve Parkway Dental HIPAA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

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 you protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make your protected health information and of other important matters about your protected health information. A copy of our Notice of Privacy is posted in our waiting area and is available to you upon request.

We reserve the tight to change our privacy practices as described in our Notice of Privacy Practices. If changes are made, we will issue a revised copy which will contain the changes.

Contact: Any member of our front desk team.
9613 Anderson Lakes Parkway, Eden Prairie MN 55344. 952-941-0470.

Right to Revoke: You have the right to revoke this Consent form at any time by giving us written notice of your revocation submitted to the contact 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 continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of the Consent and your Notice of Privacy Practices. I understand that, by signing this 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 signing on behalf of a patient complete the following:

Representatives name: _____ Realtionship:_____