Harvest Family Dentistry
(256) 852-1100
5850 Hwy 53 Suite Y
Harvest, AL 35749

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

As required by the health insurance portability and accountability act of 1996 this practice may use your personal health information for the purposes of treatment, payment or health care operations. The specific uses and disclosures that we intend to make are described in our notice of information practices. You have the right to review the notice of information practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the notice of information practices by requesting the “restriction request” form. You may revoke this consent at any time by signing and dating the revocation form. All forms are available by request.

Consent Section:

I,______________________________(print name) hereby consent to the use and disclosure of my protected health information for the purposes of treatment, payment , and health care operations. My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearing house. This protected health information relates to my past, present, and future physical and/or mental health condition.

I understand that I may request restrictions on the uses and disclosures of my health information at any time. I further understand that Harvest Family Dentistry is not required to accept my restriction request.

I understand that I may revoke this consent at any time, in writing, except to the extent that Harvest Family Dentistry has taken action in reliance on the consent.

I understand that my signature below indicates that I have been given a copy of the notice of privacy practices to review and to have any questions answered before signing. Harvest Family Dentistry reserves the right to change the privacy practices that are described in the notice of privacy practices. A revised notice may be obtained by contacting the office.

______________________________________ ______________
Signature of patient or personal representative Date

___________________________________ ______________
Print name of patient or personal representative Date

_____________________________________ ______________
Description of personal representative’s authority Date

Please list anyone that you authorize to bring you/your child to dental visits and allow to make decisions or discuss dental care.

1.____

2.____