

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Let it be known that we do not share your information with anyone other than your insurance company, other Doctors to aid in your treatment, or for possible collection purposes, or your family/guardian unless you have specifically said no.

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 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 can be obtained at the front desk. 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: Office Manager
Telephone: 801-394-4519
Address: James W. Ellis, DDS, 1220 33rd Ste. # C, Ogden, UT 84403

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.

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. I also give consent for my personal representative named: _____ to obtain health information on my behave.

*Signature: _____ Date: October 20, 2009

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

Personal Representative's Name: _____

Relationship to Patient: _____

Acknowledgement of opportunity to receive Notice of Privacy Practices

I have had the opportunity to receive a copy of this office's Notice of Privacy Practices.

I request a copy of this Privacy Practice Notice _____

I decline a copy of this Privacy Practice Notice _____

Signature: _____

You may refuse to sign this consent

For Office Use Only

- ___ Individual refused to sign
- ___ Communications barriers prohibited obtaining the acknowledgement
- ___ An emergency situation prevented us from obtaining acknowledgement
- ___ Other (Please Specify) _____

You are entitled to a copy of this consent after you sign it. You may obtain a copy of the privacy practice notice on request. This form to be included in the patient's chart records.