NORTHRIDGE FAMILY DENTAL CENTER

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient#: _____ Social Security #: _____

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 for. Our Notice provide a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make 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 Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

We may use your information to contact you. We may send newsletters or other information. We may want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answer the phone.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

OFFICE (818) 775-1300 FAX (818) 775--1465
9514 RESEDA BLVD. #6 NORTHRIDGE CA 91324

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, and that we may decline to treat you or to continue treating you if you revoke this Consent.

You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S. W. Room 509F, Washington, DC 20201. You will not be retailed against for filing a complaint.

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 healthcare operations.

Signature _____ Date _____

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

Personal Representative's Name _____

Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER SIGNING IT.

Include completed Consent in the patient's chart

This Notice goes in effect as of April 14, 2003