Diamond State Dentistry
COMPREHENSIVE FAMILY CARE

CONSENT FORM FOR USE OR DISCLOSURE OF PATIENT INFORMATION

Patient Name:_____

Patient's Date of Birth:_____Patient's Social Security Number.: _____

I hereby authorize the use and disclosure of the patient information as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

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 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.

Right to Revoke:
I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by Diamond State Dentistry's Privacy Official at 215 West Liberty Way, Milford, DE 19963. If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature of Patient or Patient's Personal Representative:
I _____, have had the 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.

Signature: _____Date_____

If Personal Representative:

Print Name:_____

Signature:_____Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT