# Dr R. Michael Whitaker DDS

CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

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**SECTION A: PATIENT GIVING CONSENT**

Patient Name: _____

Address: _____

Telephone: _____

**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 out treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our Notice accompanies the consent. We encourage you to read it carefully 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: Susan Whitaker RN – Office Manager

Telephone: (740) 454-8148 Fax: (740) 454-8413

Address: 2203 Maple Ave, Zanesville, Oh 43701

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

**SIGNATURE**

I, _____, have had full opportunity to read and consider the contents of this consent form and 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 this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Please list the name/-s of your spouse, caregiver, or any other person, that you will allow access to your protected health/account information.

_____ _____ _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**
**THIS COMPLETED COPY WILL BE KEPT IN YOUR CHART**