Consent for Use and Disclosure of Health Information

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. Until further notification by you, Gentle Dental will have authorization to any future disclosures to spouse, employer, school, medical/dental personnel for reasons you may instruct.
Right to Revoke: You will have the right to revoke this Consent at anytime by giving us written notice of your revocation submitted to the Office Manager.

This Acknowledgement applies to all minor children or dependent adults I represent. List

names: ____

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** I, (print name)____, have had full opportunity to read and consider the 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.

** Patient date of birth

____ **

Signature____

Date__________________ → Relationship to patient: (please circle one) SELF SPOUSE

PARENT LEGAL GUARDIAN

Acknowledgement of Receipt of Notice of Privacy Practices

* You may refuse to sign this Acknowledgement*

** I, (print name)____, have received/been offered a copy of this office's Notice of Privacy Practices.

** Signature

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This Acknowledgement applies to all minor children or dependent adults I represent:

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