Tri-State Center for Implant & Cosmetic Dentistry, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION – minor or unable to sign for self

SECTION A: PATIENT

Name: _____

SECTION B: 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 accompanies this Consent. If you wish to have a copy to take with you, please let us know. 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 post a revised Notice of Privacy Practices in our administrative area, 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 viewing our website, or contacting our office:

Tri-State Center for Implant & Cosmetic Dentistry, PC, 15 Vernon Ave, Ste 101, Hamburg, NJ 07419

Phone: 973-209-6252 Fax: 973-209-8787 E-mail: drgoldberg@valleydentalassoc.com

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.

SIGNATURE

I, _____, have had full opportunity to read and consider

(print name of Patient's representative)

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 Patient's protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT: PLEASE ASK FOR YOUR COPY.