



DR. Charlie Gill, DENTIST *Your Smile Maker!*

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name _____ Social Security # _____
 Street Address _____ Home phone _____
 City, State, Zip _____ Work phone _____
 E-mail address _____ Cell phone _____

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 necessary treatment, payment activities and healthcare operations which includes other healthcare professionals directly related to your treatment and insurance companies.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the 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.

You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice, at any time by contacting Dr. Gill's Office at 1200 E. Robinson Street, Orlando, Florida 32801 or calling (407) 894-0084.

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.

Who else is allowed access to information regarding your treatment or account status?

Name _____ Phone _____ Name _____ Phone _____
 Name _____ Phone _____ Name _____ Phone _____

Signature

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:

Representative's Name _____ Relationship to Patient _____