Blockley Dental

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.

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 other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices. If we change our privacy practices, we will issue a revised Notice containing the changes.
You may obtain a copy of our Notice of Privacy Practices at any time by contacting:
Contact Person: **Teresa Wilson**
Telephone: (**423) 877-8557** Fax: (**423) 870-3928**
Address:**4607 Dayton Blvd, Chattanooga, TN 37415**

RIGHT TO REVOKE
YOU WILL HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME BY GIVING US NOTICE OF YOUR REVOCATION SUBMITTED TO THE CONTACT PERSON LISTED ABOVE.

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.

Signature:_____**Date:**_____

If a personal representative on behalf of the patient signs this consent, complete the following:
Representative's Name :_____Relationship:_____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information.I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this Acknowledgement

I HAVE BEEN OFFERED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

_____
INITIAL

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of privacy practices,but acknowledgement could not be obtained because:
__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtainingacknowledgement
__ Other (Please specify)

Office staff signature_____

Authorization for Use and Disclosure of Protected Health Information.
Release of information:

I authorize the release of any and all information including diagnosis, financial, dental records: examination rendered to me and claims information. This information may be released to:

Spouse: _____
Child (ren): _____
Other: _____
Information is not to be released to anyone: _____

Please indicate preference:
Please call: Home: _____
Cell: _____
Work: _____
E-Mail: _____
Text Mess.: _____

If unable to reach me:
Please leave detailed message: Answering machine or voicemail_____
Please leave message asking me to return call _____
Please do not leave a message _____

I understand that this office will try to accommodate my wishes about my contact information, but may have to contact me at the other numbers if unable to contact me at my requested number.