

Consent for Use and Disclosure of Personal Health Information

Patient's Consent

Name:		
Address:		
City:	State:	Zip:
Telephone:	Email:	
Social Security #:		
I,, have received a copy of		
form authorizes Country Lakes Family Dental to use purposes of healthcare operations, treatment and particles.	• •	otected health information (PHI) for the
Before signing, please read our Notice of Privacy Po disclose your PHI.		understanding of how we may use and
For questions concerning our Notice of Privacy Policie	es, please contact Stac	cy Woodson at 940-455-7645.
Initial by which option you choose: I have read the Notice of Privacy Policies and I operations, treatment and payment activities.	I consent to your use	of my PHI for the purpose of healthcare
I revoke the above consent for the use and di the office of Country Lakes Family Dental reserves t	•	_
negate any prior actions while acting under consent.	•	
Signature (Patient, Parent or Guardian)		
If other than patient, please state relation:		
Office Use Only		
On, an Acknowledgement of Receipt of Notice of P	Privacy Policies form was	s delivered. The form was not signed due to:
Communication Barriers which prevent acknowle	edgment	A refusal to sign
An emergency which prevents acknowledgemen	ıt	Other

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.