Richard E. Corley, D.D.S., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Date of Birth: _____ SSN: _____

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 (PHI) 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. You have the right to refuse to sign. 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.

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.

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 heath care operations.

Signature: _____ **Date**: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name and relationship: _____

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Jennifer Amadeo Phone: (850) 654-6969 Fax: (850)654-1057 smiles@destindental.com

---

Office Use Only: As a privacy officer, I attempted to obtain the patient's (or representative's) signature on this document but did not because:

- ☐ It was emergency treatment.
- ☐ I could not communicate with the patient.
- ☐ The patient refused to sign.
- ☐ The patient was unable to sign because: _____
- ☐ Other (Please specify): _____

Signature of privacy officer: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Please put the name of each person who is allowed to receive or inquire about your dental information (including: financial or medical information such as; Appointments, dental treatment, finances and dental records).

☐ Spouse (name and phone number): _____

☐ Parent (name and phone number): _____

☐ Other (name, phone number and relationship to patient): _____

☐ I do not authorize anyone other than myself to receive or inquire about any of my dental information.

By signing this release of information, I authorize Emerald Coast Dental to release my protected information to the persons listed above.

_____ **Date:** _____

Signature of Patient or Personal Representative