SHIFLETT FAMILY
DENTAL

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____

Address:_____

Home Phone:_____Work Phone:_____Cell:_____

E-Mail:_____ Social Security Number:_____

I have had the opportunity to read and consider the contents of 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 health care operations.

Signature: _____Date:_____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will ***not*** affect in any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.