

Redmond Way Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME (Print) _____

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 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 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 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 written copy of our Notice of Privacy Practices at any time by contacting:

Contact Officer: Becky Ferrell
Telephone: 425-898-2168

Right to Revoke: You 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 prior to your revocation.

I, as the Patient or the Patient’s Representative, 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 health care operations. In addition, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY **SPOUSE / PARTNER ONLY** **OTHER** _____

Patient Signature: _____ **Date:** _____

If this Consent is signed by a Personal Representative on behalf of the patient, please complete the following:

Representative’s Name : (print) _____

Representative’s Signature : _____ **Date:** _____

Relationship to Patient : _____

Please complete the following ONLY if you would like a copy of this form. You are entitled to a copy.

(Include completed Consent in the patient’s chart.)

*******Acknowledgement of Receipt of Notice of Privacy Practices*******

You may refuse to sign this acknowledgement

Patient’s Name: (print) _____ **Date** _____

Patient’s Signature: _____

I, (Print signature name, if signing as Representative) _____, have received a copy of this office’s Notice of Privacy Practices. Signature of Representative _____

We attempted to obtain written acknowledgment 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 obtaining acknowledgment
- Other (Please specify) _____