



CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT GIVING CONSENT: _____
ADDRESS: _____
TEL: (____) ____-____ EMAIL: _____
BUS TEL: (____) ____-____ CELL #: (____) ____-____
SOCIAL SECURITY # _____

TO THE PATIENT – PLEASE READ THE FOLLOWING 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. We reserve the right to share all information relating to your treatment with your immediate family. You are entitled to a copy of this form after signing.

NOTICE OF PRIVACY PRACTICE: You have a 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 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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. I release, hold harmless, and agree to indemnify Palm Beach Center for Periodontics & Implant Dentistry, P.A., the employees, and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this consent. I specifically authorize Palm Beach Center for Periodontics & Implant Dentistry, P.A. use and disclosure verbally, by mail, fax, or encrypted email, the following types of super-confidential information as stated in the Notice of Privacy Practices.

Initial Where Appropriate:

- _____ HIV records (including HIV test results) and sexually transmissible diseases
- _____ Alcohol and substance abuse diagnosis and treatment records
- _____ Psychotherapy records

You may obtain a copy of your Notice of Privacy, including any revisions, at any time by contacting our Privacy Officer: Dr. Lee R. Cohen, 4520 Donald Ross Road, Suite 110, Palm Beach Gardens, Florida 33418
Tel: (561) 691-0020 Fax: (561) 691-9707

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of your revocation. This should be submitted to our Privacy Officer, as 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 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 Practice. I understand that by signing this consent form, I am giving my consent to you to disclose my protected health information to carry out treatment, payment activities, and healthcare operation. I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this consent, complete the following:

Representative: _____ Relationship to Patient: _____