



DEEANN BENNETT DDS, PA
cosmetic and family dentistry

**Consent for Use and Disclosure of Health Information & Acknowledgement of
Receipt of Notice of Privacy Practices**

Section A: Patient Giving Consent

Patients Name _____ Social Security Number _____

Address _____ Telephone _____

Section B: To the Patient---Please read carefully

Purpose of Consent: By signing this form, you will give consent for our office to use and disclose 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, healthcare operations, 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 Practice 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 copy of our Notice of Privacy Practices, including any revisions of our notice at anytime by contacting: Vickie Oldenbuttel, 220 South Denton Tap Road Suite 102, Coppell, Texas 75019, 972-462-9000.

Right to Revoke: You will have the right to revoke this consent at anytime 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 revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

****Signature** You may refuse to sign this---you are entitled to a copy of this consent after you sign it****

I, _____, have had the 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 healthcare operations. I have reviewed a copy of the office's notice of privacy practices.

Signature _____ Date _____

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

Patient Representative _____ Relation to Patient _____