LAKEVIEW DENTAL, LTD
CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient's name: ____Birthdate: __________________

May share information with spouse/significant other YES NO Name: ____________________________

& or - May share information with parent/parents: YES NO Name(s): ____________________________

& or - May share information with ____________________________ Name: ______________________________

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 to carry out treatment, payment activities, and other 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 is available with this Consent. We encourage you to read it carefully and completely before signing this Consent.

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: **Lakeview Dental, LTD.**

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: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT: ***DO NOT SIGN THIS PORTION UNLESS YOU ARE REVOKING YOUR CONSENT***

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. i understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: ______________________________