CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SECTION A: PATIENT GIVING CONSENT

NAME: _____

Purpose of Consent: By signing you 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 a right to read our Privacy Practices before you sign. A copy of our Notice accompanies this consent form. You may obtain a copy of our Notice of Privacy Practices by contacting:

Judith Chandran
(402) 957-2193
19060 Q Street, Suite #106
Omaha, NE 68135
Or visit our website: www.Springhilldentalomaha.com

Right to Revoke: You have the right to revoke this consent at any time by giving written notice to the contact person above.

I, _____have had the

opportunity to read and consider the contents of this Consent and Notice of Privacy Practices.

X Signature: _____ Date: _____

If this Consent is signed by a personal representative of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM