CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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 your 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 your Notice is posted in the office and may be requested at any time. 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 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 Practice, including any revisions of our Notice, at any time by contacting:

HIPAA Administrator as assigned by Scott A. Watterson, D.D.S.
1030 Laurence Avenue, Suite 3
Jackson, MI 49202
Telephone: 517-782-1467 Fax: 517-782-3659

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 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 your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Family and Friends:

By signing this Consent, you are permitting us to disclose personal health information to your family, friends or other person to the extent necessary to help with your healthcare or with payment for your healthcare. Also understand that failure to agree to this Consent will eliminate the possibility of us contacting your family and/or friends with regards to your appointments, payment and any other issues in which we currently use these people to communicate with you.

Signature

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 health care operations.

Signature: _____ Date: _____

***Office Use Only**: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:*

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