CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

for updated guidelines effective June 2016

Name: _____

Date of Birth:_____

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 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 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 Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

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 at our office, Lisa Taylor (706) 896-4154. 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.

SIGNATURES

I, _____(print name), 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:

_____ Date: _____

Relationship to Patient:

_____

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.
I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.

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.
Include completed Consent in the patient's chart.

Personal Health Information Disclosure Agreement

Samuel Jason Ledford, DMD, PC

I, _____, do hereby grant permission for Samuel Jason Ledford, DMD, PC, to disclose my personal health information to the following personal representatives(s):

(please indicate relationship next to name such as spouse, sibling, parent, child, friend, etc.)

_____
_____
_____
_____

Information to be disclosed (please check all that apply):

_____Appointment dates and times

_____Treatment plans and referrals

_____Financial and billing information

_____Any other pertinent dental health information related to treatment at this office.

_____None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Samuel Jason Ledford, DMD, PC.

_____

Patient Signature

Date

_____

Patient's Date of Birth

_____

Relationship to Patient if Patient is a Child Under age 18

_____