

William W. Schell, DDS, MAGD, FACD

Consent for Use, Disclosure and Receipt of Privacy Practices

TO THE PATIENT-PLEASE READ THE FOLLOWIN`G 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 is available upon request.

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, 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, including any revisions, at any time by contacting the Privacy Officer at our office.

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 to treat you if you revoke this Consent.

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.

_____	_____
Patient Name/Guardian	Date
_____	_____
_____	_____
Persons to whom we may share information	Relation to Patient

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