CAMAS DENTISTRY

NOTICE OF PRIVACY PRACTICES

AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name (print): _____

To the Patient – please read the following statement 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 practice 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 Practices including any revisions of our Notice at any time by contacting: Marcela Arroyave at 360-828-5502.

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.

You are entitled to a copy of this Consent after you sign it. A copy of this Consent will be stored in your patient profile.

****Signature****

I, as the Patient or the Patient's Representative, 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 office to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient Signature: _____Date: _____

If this Consent is signed by a Personal Representative on behalf of the patient, please complete the following:

Representative's Name (print): _____Relationship to Patient:_____

Representative's Signature: _____Date: ___/___/___

Acknowledgement of Receipt of Notice of Privacy Practices (you may refuse to sign this acknowledgement)

CAMAS DENTISTRY

Patient Signature: _____Date: ___/___/___

I, (print signature name, if signing as Representative) _____, have received a copy of this office's Notice of Privacy Practices.

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

__ communication barriers prohibited the acknowledgement

__ an emergency situation prevented us from obtaining acknowledgement

__ individual refused to sign __ other _____