CENTER FOR ORAL HEALTH

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:

Address:

Telephone: Social Security Number:

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment

I, , have had full opportunity to read and consider the cor

I authorize the following person(s) to have access to my protected health information:

Signature: Date:

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.