CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient Name: _____ Telephone #_____

Address: _____

Section B: To the Patient

Please read the following statement carefully. The purpose of this form is for you to 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 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 protected health information, and of other important matters about your protected health information. A copy of our Notice is posted on the wall in our reception area. We encourage you to read it carefully and completely before signing the 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 healthcare information that we maintain.

You obtain a copy of our Notice of Privacy Practice, including any revisions of our Notice, at any time by contacting:

Matthew Quinlivan, DDS
(919) 467-8111
149 W. Chatham Street, Cary, NC 27511

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation and submitting it to the contact person listed above. Please understand that the revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you continue treating you if you revoke this consent.

Signature: (Patient, Parent, or Guardian)

I _____ have read and understand the contents of this consent form and Our Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to Dr. Quinlivan's office to use and disclose of my health information to carry out treatment, payment activities, contacting the insurance commissioner on my behalf, and healthcare operations.

Signature of representative: _____ Date:_____

This consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representative's name: _____

Relationship to patient: _____