



CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

"You may refuse to sign this acknowledgement"

A: PATIENT GIVING CONSENT

Name: _____
(please print)

B: 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 carryout 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.

You have received a copy of our Notice of Privacy Practices, including any revisions. Additional copies are available at any time by contacting us at:

Telephone: (585)292-1270 Fax: (585)292-0219

E-mail: ComfortCare@frontiernet.net

Address: 2024 West Henrietta Road Suite 5J, Rochester NY 14623

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.

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 heath care operations.

In addition I give my permission for the followlng Individual to be informed about my dental needs and the finances pertaining same :

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient or guardian signature: _____ Date: _____