

Frederick R. Levine, D.D.S.

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Date of Birth _____ SS# _____

Address: _____

Home Telephone: _____ Work#: _____ Cell#: _____

SECTION 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 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. A copy of our Notice accompanies this form. We encourage you to read it carefully and completely before signing. Our Notice provides a description of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

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. At any time you may obtain a copy of our Notice of Privacy Practices, including any revisions by contacting us at: Phone (518)370-0223, Fax (518) 370-3382, or mail - 2142 Rosa Road ~ Schenectady, NY 12309

Office Communications: Please review/complete the following questions regarding communication with our office.

I hereby give permission for this office to leave detailed information at my HOME WORK CELL phone number(s) regarding:

Appointments Only All health related information Do not leave messages

I hereby give permission to this office to discuss my health, insurance, and other pertinent information with the following people(s)

Name _____ Relationship _____

Name _____ Relationship _____

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, healthcare operations and/or for uses otherwise noted in the NOTICE OF PRIVACY PRACTICES for Frederick R. Levine, D.D.S.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, you must complete the following:

Personal Representative's Name: _____ Relationship to Patient _____

Right to Revoke: You 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. **(See Reverse Side For Revocation of Consent)**

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

STOP

THIS IS A REVOCATION OF CONSENT.

DO NOT SIGN BELOW UNLESS:

YOU HAVE PREVIOUSLY SIGNED A CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION AND ***HAVE DECIDED THAT YOU NO LONGER AGREE TO THE TERMS DISCLOSED IN OUR NOTICE OF PRIVACY PRACTICES.***

REVOCATION OF CONSENT

Patient Name _____ (PRINTED)

Parent/Guardian Name _____ (PRINTED)

I hereby revoke my Consent for your use and disclosure of protected health information regarding the above named patient for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation is signed by a personal representative on behalf of the patient, you must complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____