DENTAL ARTS CENTER
Jonathan E. Beaugez, D.M.D.
IMPLANTS.GENERAL.COSMETIC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Birth Date: _____
Last First mm/dd/yyyy

PURPOSE OF CONSENT:

By signing will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE:

I, _____ have had full opportunity to read and consider this consent and have
(Please type)
received and read 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 healthcare operations.

_____ _____

Signature **Date**

If this consent is signed by a guardian or personal representative on behalf of the patient, complete the following:

Relationship to patient: _____

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RIGHT TO REVOKE:

You have the right to revoke this consent. Please understand that he revocation of the consent will not affect any action we took in reliance of the consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

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

Staff: (Please have patient sign by marked box and then initial signature)

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (please specify)