## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**for updated guidelines effective August 2013**

**Name: _____ Date of Birth:_____**

### 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. 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.

**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.

### SIGNATURES

**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.**

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

### EMAILING X-RAYS

**In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.**

**I understand that x-rays might need to be emailed to other specialists and dentists. I give my permission for this service.**

Signature: _____ Date: _____

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

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.**

## I, _____, do hereby grant permission for Nilay Nanavati, DDS, to disclose my personal health information to the following personal representatives(s): (spouse, sibling, parent, child, friend, etc.)

_____

_____ _____

## Information to be disclosed (please check):

- ❑ **Appointment dates and times**
- ❑ **Treatment plans and referrals**
- ❑ **Financial and billing information**
- ❑ **Any other pertinent dental health information related to treatment at this office.**
- ❑ **None of the above**

## I understand that this permission will remain in effect unless a written cancellation has been provided to Nilay Nanavati, DDS.

_____ _____

**Patient Signature Date**

_____

**Patient's Date of Birth**