Acknowledgement of receipt of privacy practices

I _____, have received a copy of this office's Notice of Privacy Practices.

I _____, have had the 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 health care operations.

Our Policy:
Consent and Disclosure of Health Information
Please read the following statements carefully.

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. 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 and of the uses and disclosures we may make of your protected health information, and of other important matters about your protected heath information. A copy of our notice accompanies this consent, we encourage you to read it carefully and competently before signing this consent. We reserve the right change our privacy practices as described in our notice. If we change our privacy practices we will issue a revised notice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting:

Pryor Dental Center
1909 S. Elliott * Pryor, OK 74361
Phone: (918) 825-0941 Fax: (918) 825-1463
pryordentalcenter.com

You are entitled to a copy of this consent after you sign it upon request. You have the right to revoke this consent at any time by providing us with a written notice of your revocation submitted to the business office manager at the address listed on this notice. Please understand that 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 or decline to continue treating you, if you revoke this consent.

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

Personal representatives
(Ex: Mom, Dad, Guardian…)

Name: _____

Relationship to Patient: _____

Patient/ Guardian Sign & Date

Patient Name: _____

Patient DOB: _____

Date: _____

Signature: _____

Revocation of Consent: by signing below this statement for revocation - I revoke my consent for your use and disclosure of my protected health information 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. Sign and date below to revoke.