# ALVAREZ DENTAL, PLLC

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Patient Name: _____ DOB _____**

**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 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 is posted on the wall of the waiting area. If you need a copy, please ask our receptionist. 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 on Policy Practices, 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, including any revisions of our notice, at any time by contacting:

Contact Person: Lucy Alvarez, Office Manager Address: Alvarez Dental, PLLC, 123 Whitehall Road, Albany, NY 12209 Telephone: (518) 436-9771 Fax: (518)436-9794

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 the 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 continue treating you if you revoke this consent.

I _____, have had the 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 health care operations.

Signature: _____ Date: _____

(If you would like anyone to have access to you information (billing, conditions, insurance, etc) please print their names and relationships here:

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