

# *Notice of Privacy Practices & Consent for Health Disclosure*

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payments 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 make of your protected health information and of other important matters about our protected health information. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described by our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practice, 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 this office: Philp Family Dentistry Waconia, 9366 Oak Avenue, Waconia, MN 55387, 952-442-4891 or on our website [philpfamilydentistry.com](http://philpfamilydentistry.com).

**RIGHT TO 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 Office 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 discontinue treating you if you revoke this Consent.

**ASSIGNMENT AND RELEASE:** I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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 health care opportunities.