Fredric J. Witkin D.D.S. PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT – Please Print

Name:_____

Address:_____

Telephone:_____E-mail:_____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENT CAREFULLY:

Purpose of Consent: By signing the 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 operation, 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our front desk:

Contact Person: Any front desk staff person can assist in obtaining copies **Privacy Officer**: Mary Elizabeth Thomas

Telephone: 305-662 2216 **Fax:** 305-633-6647 **E-mail**: WCPerio@bellsouth.net

Address: 8861 S.W. 69th CT Miami FL 33156

Right to Revoke: You will have the right revoke this Consent at any time by giving us written notice of your revocation submitted to privacy officer listed above.

I, (print your name) _____, 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, and health care operations.

X

Patient Name (Please Print) Date

X

Patient Signature or Signature of Personal Representative
Authority of Personal Representative to Sign for Patient (check one):
[ ] Parent [ ] Guardian [ ] Power of Attorney [ ] Other:_____