JAMES W. TRIANT, DDS, PC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

	1 - 1000
SECTION A: PATIENT GIVING	CONSENT
Name:	
Name	
Address:	
	E-maile
Telephone:	E-mail:
Patient #:	Social Security #:
SECTION B: TO THE PATE	ENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
mation to carry out treatment, pa	ng this form, you will consent to our use and disclosure of your protected health info ayment activities, and healthcare operations. You will also consent to our office sending r leaving you a telephone message, regarding appointment specifics.
Notice of Privacy Practices: to sign this Consent. Our Notice ations, of the uses and disclosi	You have the right to read our Notice of Privacy Practices before you decide whether the provides a description of our treatment, payment activities, and healthcare oper- tures we may make of your protected health information, and of other important mat- th information. A copy of our Notice accompanies this Consent. We encourage you to
our privacy practices, we will i	our privacy practices as described in our Notice of Privacy Practices. If we change ssue a revised Notice of Privacy Practices, which will contain the changes. Those ur protected health information that we maintain.
You may obtain a copy of our Not	tice of Privacy Practices, including any revisions of our Notice, at any time by contacting
Contact Person:	
THE RESERVED TO SECURITION OF	The state of the s
Telephone:	Fax: Biddin time Place to a very described
E-mail:	15 N 81 D 201 A 11 V 201 A 2
Address:	Fig. 12 - Little House and School and Control of Contro
Right to Revoke: You will ha revocation submitted to the Co affect any action we took in reli	ove the right to revoke this Consent at any time by giving us written notice of your ntact Person listed above. Please understand that revocation of this Consent will not ance on this Consent before we received your revocation, and that we may decline to go you if you revoke this Consent.
SIGNATURE	
I,	, have had full opportunity to read and consider the and your Notice of Privacy Practices. I understand that, by signing this Consent to your use and disclosure of my protected health information to carry out treatment are operations.
Signature:	Date:
	ersonal representative on behalf of the patient, complete the following:
Personal Representative's Name:_	
Polationchio to Patient:	
MAINTARCHIO TO MATIBOLI	

JAMES W. TRIANT, DDS, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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