DR. BETH HENDLIN DDS
1301 River Street
Valatie NY, 12184
518-758-9291

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATEINT GIVING CONSENT

Name_____

Address_____

Telephone_____ Email_____

Patient #_____ Social Security #_____

SECTION B: 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 whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and health care operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected 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

*Contact Person Holly Calyer, Office MGR*_____

*Telephone 518-758-9291*_____

*Email DOCB@NYCAP.RR.COM*_____

*Address 1301 RIVER STREET, VALATIE NY, 12184*_____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of our revocation submitted to the Contact Person listed above. Please understand that revocation for this Consent will not affect any action we take in reliance on this Consent before we received your revocation, and that we may decline to you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have full opportunity to read and consider the contents of the Consent form and you Notice of Privacy Practices. I understand that be 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 this consent is signed by a personal representative on behalf of the patent complete the following

Patent's Representative Name_____

Relationship to Patient _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.