Kenwood Advanced Dentistry LLC

Michael L. Prater DMD

Consent for use and disclosure of health information/records

Name:_____

Address:_____

Phone:_____ Email:_____

Social Security: _____

Section B: To the patient – Read the following statements carefully section A: Patient giving consent

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 health records.

Notice of Privacy Practice: 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 your treatment, payment activities, and health records, 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 complete before signing this Consent.

We reserve the right to charge our privacy practices as described in our notice of Privacy Practices. If we change our privacy practice, 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: _____

Telephone: (513) 793-3722_____

Fax: 513-793-2706_____

Address: 8040 Hosbrook Road Suite 230, Cincinnati Ohio 45236_____

Email: mpraterdmd@hotmail.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 Consent Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance in this Consent before we receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

Signature: _____

I _____, have had full opportunity to read and understand the contents of this Consent form, and Notice of Privacy Practices. I understand that by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care records.

Signature: _____ Date: _____

IF THIS CONSETN IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

Personal Representative Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT (Include completed Consent in the patient chart)