CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
DR. GLEN MITCHELL ENDODONTICS

Patient Name: _____

PLEASE READ THE FOLLOWING STATEMENT 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 healthcare operations 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 is available to you upon request.

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. These 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:

Dr. Glen Mitchell or Barbara Bolotin
900 Glades Rd #3a, Boca Raton, FL 33431
Phone: 561 368-3636 Fax: 561 368-8997

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 Person 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 to continue treating you if you revoke this Consent.

CONSENT:
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 operations.

_____ _____
Patient (Guardian) Signature Date

The HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I may be contacted in the following manner (please check all that apply):

Home Telephone:

OK to leave message with details: YES ☐ NO ☐ Postcard (open-faced) YES ☐ NO ☐
Leave message with call-back number only: YES ☐ NO ☐ OK to mail to my home address YES ☐ NO ☐

Work Telephone:

OK to mail to my work/office address: YES ☐ NO ☐ OK to leave message with detailed information YES ☐ NO ☐
OK to fax: YES ☐ NO ☐ Fax Number: _____
Leave message with call-back number only: YES ☐ NO ☐ Other: _____

I allow you to give my clinical information to, or answer questions from (check all that apply):

☐ Spouse
☐ Parent
☐ Child
☐ None
☐ Other: _____

_____ _____
Patient (Guardian) Signature Date