FURROW FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have read this office's **Notice of Privacy Practices** and understand I can request a copy at any time. A copy of this signed and dated document shall be as effective as the original. By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities, and health care operations. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, a new Notice of Privacy Practices will be issued. These changes may apply to any of your protected health information we maintain.

Consent does not expire after one year. By signing this consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein:

1) The release of health records to a provider for consultations
2) The release of health records to an accident or health insurer, health service plan corporation, health maintenance organization, or third-party administrator for the purpose of payment of claims, fraud investigation, or quality of care reviews.

You have the **right to revoke** this consent at any time by giving us written notice of your revocation, submitted to the office of Furrow Family Dentistry, PLC. 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 continue treating you if you revoke this consent.

Patient Name: _____ Date: _____

Patient/Guardian Signature: _____

May we leave personal medical information on your phone answering machine? **Yes / No**

May we email personal medical information to you? **Yes / No**

Please list any other parties who can have access to your personal health information, including receiving information about appointments, treatments performed, and dental benefits. *This includes spouses, partners, children, parents, grandparents, and caretakers.*

Name: _____ Relationship: _____

Limitations: _____

Name: _____ Relationship: _____

Limitations: _____