Boulos Dental Care
ACKNOWLEDGEMENT AND CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

NAME:_____

SECTION B TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 accompanies this Consent. We encourage you to read it carefully and completely before signing this 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, Healthcare Operations, Subpoenas, Immunization Information, Notice of Privacy Practices, Minnesota Healthcare Bill of Rights, Workers Compensation, Patient Access, Minors, Provider to Provider, Communication via email, text, USPS, Phone or 3rd party company authorized by Boulos Dental Center.

PURPOSE OF ACKNOWLEDGEMENT: By signing this form you acknowledge you had the opportunity to read our Notice of Privacy Act for Boulos Dental Care.
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 Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting. Contact Person: Lisa Smith Address: 470 Hwy 96 W #200 Shoreview MN 55126

SIGNATURE:

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.

Signature: _____Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ___

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.

REVOCATION OF CONSENT: 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 revoke this Consent.

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____Date:_____-