Consent for Use and Disclosure of Health Information

Patient Giving Consent: ____

Please read the following statements carefully and sign at the * Signature:**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, referral to or sharing your treatment or health information with a needed dental specialist, payment activities, and health care operations.

Notice of Privacy Practices: Our Notice provides a description of your treatment planned and completed, health history information, payment activities, and health care operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

I consent to the HIPAA practices of Christopher D. Elson D.D.S. Please check __Yes __ No

**If this Consent is signed by a parent or personal representative on behalf of the patient, complete the following:

Representative's Name: ______________________________ Relationship to Patient: __________

** Representative's Signature: ______________________________ Date: ______________

I also give consent for my treatment and financial arrangements to be discussed with:

____

***** Signature: ____ Date: ______________**

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, by contacting:

Office of
Christopher D. Elson D.D.S.
7373 W. Jefferson Ave Suite 403
Lakewood, CO 80235

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. By signing below you acknowledge you have had a full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. You also consent to our use and disclosure of protected health information to carry out treatment, payment activities and heath care operations.

REVOCATION OF CONSENT (Do Not Sign This Portion Unless You Are Revoking Your Consent)
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care 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 or to continue to treat me after I have revoked my Consent.
Signature: ____ Date: ______________________
You are entitled to a copy of this consent after you sign it.