NORTH END DENTAL
704 N. 17th Street
Boise, ID 83702

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

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: A copy of our Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

You may obtain additional copies of our Notice of Privacy Practices by contacting:

North End Dental
704 N. 17th Street
Boise, ID 83702
344-0134

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact 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.

SIGNATURE

I,_____, have had full opportunity to read and consider the contents of this Consent form and have received and read 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 guardian or personal representative on behalf of the patient, complete the following:

Patient Name: _____

Relationship to Patient: _____

PLEASE RETURN THIS FORM TO OUR OFFICE