

**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

**SECTION A: To be completed by patient giving consent. Please Print.**

Patient Name:

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**SECTION B: Important Information. PLEASE READ THE FOLLOWING CAREFULLY.**

**Purpose of Consent:** By signing this form, you will be giving your consent to our use and disclosure of your protected health information. This information will be utilized solely for the rendering of dental treatment, associated payment activities, and other related healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this Consent. Our Notice provides a detailed description of our treatment, payment activities, and healthcare operations; of the uses and disclosures we may make regarding your protected healthcare information; and of other important matters regarding your protected healthcare information. A copy of our Notice of Privacy Practices is displayed in our office for convenience. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our Privacy Practices as circumstances may dictate and within the limits of the law. 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, at any time by contacting:

**Contact Person: Office Manager**  
**Telephone: (907) 272-6122**  
**Address: 1842 W. Northern Lights Blvd., Anchorage, Alaska 99517**

**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 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.

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 healthcare operations.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

Please check here if your consent is being given on behalf of a minor family member or an individual otherwise unable to complete this form. Please complete the following:

\_\_\_\_\_  
Your Name

\_\_\_\_\_  
Your Relationship to the Patient

I, \_\_\_\_\_; acknowledgments that on, \_\_\_\_\_ have, on behalf of myself and/or a minor or an incapacitated dependent, read and understand Turnagain Dental Office's Notice of Privacy Practices.

**For Office Use Only**

An attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices was made; however, acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)