ABERDEEN DENTAL ASSOCIATES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT: Name _____

Address: see New Patient Registration Form

Persons Involved in Care:
List individuals who you would like involved in your dental care. By writing their names on this form, you consent to the release of your dental information to them. (For example, if you want us to be able to discuss dental information with your husband/wife, you must list their names below. This includes discussing fillings, crowns, insurance payments with them.) In addition, the account holder (not necessarily the insurance holder) may receive basic dental treatment information on mailed billing statements (example...John had cleaning on 1/1/07, Mary had filling on 1/1/07).

_____ _____

_____ _____

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. If you decide not to sign this consent, we may decline to treat you.

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.

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, at any time by contacting Jennifer Graham. Telephone: 763-786-4280. Fax: 763-754-6226. Address: 11800 Aberdeen St. NE, Suite 110, Blaine, MN 55449.

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 the 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 if you revoke this Consent.

CONSENT
I have had full opportunity to read and consider the contents of this consent form. 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 / guardian on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.