ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICE POLICIES
AND
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Terry L. Norris, DMD
The Springs Health Centre
2200 East Parrish Avenue
Building C - Suite 201
Owensboro, Kentucky 42303

SECTION A: PATIENT GIVING CONSENT

Name: _____

Other dependents or guardians you wish to be covered by this consent: _____

_____ _____

Other persons you allow us to give your health information to: _____

_____ _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Acknowledgment of Receipt: By signing this form you acknowledge that you have read the Notice of Privacy Policies and are in agreement with the content stated.

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 health care operations.

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 or our Notice, at any time by contacting:

Tresa G. Wells, Office Manager
2200 East Parrish Avenue
Building C - Suite 201
Owensboro, Kentucky 42303
270-683-3269 or fax 270-689-9107

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.

SIGNATURE

By signing this form I acknowledge that I have had full opportunity to read and consider the contents of this Acknowledgment and Consent form and the Notice of Privacy Practices. I understand that, by signing this form, I am giving my acknowledgment and consent for 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

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 or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____