Orchard Park Prosthodontics, LLP
Orchard Park Periodontics, LLC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

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. This information includes, but is not limited to, radiographs, progress notes, medical history, as well as de-identified materials such as casts, photographs and other materials used in the restoration of dental, oral and facial tissues.

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 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:

Contact Person: Pamela Almeter
Telephone: (716) 662 7229 Fax: (716) 662 7263
Address: Orchard Park Prosthodontics, LLP 6435 Webster Road, Orchard Park, N.Y. 14127

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 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 consent to your use and disclosure of my protected health information to carry out treatment, payment and health care operations.

You have my permission to contact _____ in an emergency or to discuss my health information as it pertains to my treatment, payment and health care operations.

You have my permission to communicate with me electronically at: _____
I understand there is some level of risk that third parties might be able to read unencrypted e-mails.

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