Katrina A. Wall, DMD
Essex Dentist

PATIENT OR GUARDIAN GIVING CONSENT/ HIPPA

Name: _____

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 (ie, submitting to insurance companies on your bebalf), and healthcare operations.

Notice of Privacy Practices: You have the right to read our 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 is displayed in our office. 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 Practice. 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: **Laurie Groh** Telephone: **767-2262** Address: **180 Westbrook Road #6 Essex, CT 06426**

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.

My information may be released regarding billing, treatment and or conditions to the following individuals:

_____/_____

_____ / _____

I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that, by signing this Consent form. I am giving my consent to use and disclosure of my health information to carry out treatment, payment activities and health care operations. Without consent my treatment may not be submitted to my insurance company.

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Decline of permission to disperse healthcare information