Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) /Electronic Protected health information (e-PHI), for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI/e-PHI.

For questions concerning our Notice of Privacy Policies, please contact:

Our Office Manager at (541) 476-7781.

Patient's Consent

Name: _____ Date of Birth_____

I, _____, have read Southern Oregon Dental's Notice of Privacy Policies and I consent to use of my PHI/e-PHI for the purposes of healthcare operations, treatment and payment activities.*

I, _____, also give Southern Oregon Dental permission to discuss or release my dental records and PHI/e-PHI to the names listed below.*

Name _____ Name_____

Name_____ Name_____

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 have the right to revoke this consent in writing, except where we have already made disclosures in reliance on your prior consent.

Southern Oregon Dental LLC

Patient Acknowledgement
Receipt of Privacy Notice

I, _____ hereby affirm that I have received a copy of the *Notice of Privacy Practices* from Southern Oregon Dental LLC . Under federal law 104-191, also known as HIPAA, I am entitled to receive a copy of this *Notice* from my healthcare provider.

I understand that my signature on this Acknowledgement only signifies that I have received a copy of the *Notice*, and does not legally bind or obligate me in any way.

I understand that I am entitled to receive a copy of the *Notice of Privacy Practices* from my healthcare provider, whether I sign this Acknowledgement or not.

Patient Name: _____

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority (if applicable)

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:	
Date Received:	Time Received:
Patient Declined ☐	
Staff Signature:	