



DAVID M. MCGAFFIN
D.D.S., P.A.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Name: _____ Social Security #: _____

Address: _____

Please list ANY telephone number where we may contact you: _____

Please list the names of ALL people (spouse, parents, etc.) you authorize us to release your health information to, including copies of your records if needed: _____

E-mail: _____

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 health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. You may obtain a copy of our Notice, at any time. **Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice. 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 continue treating you if you revoke this Consent.

I, _____, have had the opportunity to read the contents of this Consent form and your Notice of Privacy Practices. 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 on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I request and authorize Dr. _____ and _____ to release my health care information to:

Name: _____

Address: _____

Reason for requesting records: _____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization. If I choose to cancel this agreement, I can write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter. Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Signature of patient or patient's authorized representative Date

Relationship or status if signed by parent, legal guardian, personal representative, etc.

You are entitled to a copy of this consent. The signed consent will be scanned into the patient's chart.