CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: ______________________________________

Date of Birth: _______________________________________

TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

The Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our revised notice of privacy practices(effective 09/19/2014) before you sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make about your protected health information, and of the other important matters about your protected health information. A copy of our notice is available upon request.

I, _________________________________, have had full opportunity to read and consider the contents of this Consent form and have either read or declined to read the Notice of Privacy Practices as provided under the Federal HIPAA regulation. I understand that by signing this consent form, I am giving consent to Crossbridge Dental, P.C. to use and disclose my personal health information to carry out treatment, payment activities and healthcare operations.

In addition I authorize the sharing of my protected health information with:______________________________

Signature: ____

Print Name: ____ **Date:** ______________________

If this consent is signed by a guardian or personal representative of a minor child or on behalf of a patient, please complete the following:

Name of Guardian or Representative: ____

Relationship to Patient: ____

2000 Winton Road South
Building 4, Suite 300
Rochester, New York 14618
(585) 427-2620