

GARY SQUYRES D.D.S., P.A., FAMILY & COSMETIC DENTISTRY

**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

**SECTION A: PATIENT GIVING CONSENT**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PATIENT NUMBER: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

**SECTION B: TO THE PATIENT 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.

**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 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 accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Gary Squyres D.D.S, P.A

Telephone: 281-252-8809

Fax: 281-252-8839

Email: [info@magnoliasmiles.com](mailto:info@magnoliasmiles.com)

Address: 514 Honea Egypt Rd. Ste. #100 Magnolia, TX 77354

**Right to Revoke:** You will have the right to revoke the 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.

**SIGNATURE**

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

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.  
Include completed Consent in the patient's chart.**

REVOCAION OF CONSENT

I revoke my consent of your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

\*\*\*You May Refuse to Sign This Acknowledgement\*\*\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
( Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
**FOR OFFICE USE ONLY**  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

\*Individual refused to sign

\*Communications barriers prohibited obtaining the acknowledgement

\*An emergency situation prevented us from obtaining acknowledgement

\*Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_