CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION
Section A: Patient Giving Consent

Name:_____

Address:_____

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 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 accompanies this Consent. We encourage you 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 Practices. 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.

- 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.

- Fees & Payments: Although we accept payments from your insurance company towards your account, you are responsible for your full account. I am aware that they accept MasterCard and Visa. WE ARE A PARTICIPATING PROVIDER FOR SOME INSURANCE COMPANIES. I am also aware that my balance must be cleared within three (3) months from the day of treatment. I realize that in the event my account becomes past due and is turned over for collection, I agree to pay the collection fee based on my amount outstanding. This signature on file is my authorization for the release of information necessary to process my claim. Thereby authorize payment to this doctor named of the benefits otherwise payable to me.

SIGNATURE OF GUARANTOR_____DATE_____

- 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 care 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.

- Revocation of Consent: I revoke my Consent for 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.

Witness Patient, Parent or Guardian Date

Witness Doctor Dmitry B. Kobelev DDS