RESTORATIVE, COSMETIC & FAMILY DENTISTRY

NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT GIVING CONSENT- PLEASE READ 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, insurance claims, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have received and have had the opportunity to read our Notice of Privacy Practices before you decide whether to sign the 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 to 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. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

CONTACT PERSON	**Dr. Jeffrey M. Gregson**
ADDRESS	**3812 Ridgelake Drive, Suite 300, Metairie, Louisiana 70002**
PHONE	**(504) 849-0190**
FAX	**(504) 849-0192**

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Persons 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 Below Acknowledges Receipt of Notice of Privacy Practices and Consent for the Use and Disclosure of Your Health Information:

I, *(Please Print Name)* _____ 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 healthcare operations.

Signature _____ Date _____

IF A PERSONAL REPRESENTATIVE ON BEHALF OF THE PATIENT SIGNS THIS CONSENT, COMPLETE THE FOLLOWING:

Representative's Name: _____ Relationship to Patient: _____

FOR OFFICE USE ONLY

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify) _____