STEPHEN W. SHIVER, D.M.D., P.C.
410 EAST MCPHERSON AVENUE ♦ NASHVILLE, GEORGIA 31639 ♦ 229-686-7451 ♦ 229-686-7547 (FAX)

CONSENT FOR USE AND DISCLOUSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Full Name_____

Address_____

Telephone_____ SSN_____

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 your treatment, payment activities, and healthcare operations, of the uses and disclosures we may make to your protected health information, and of other information 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:
Mandy Howell
229-686-7451, fax 229-686-7547
410 East McPherson Avenue | Nashville, GA 31639

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 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 care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____Relationship: _____

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 of my *Consent* before you received this written notice of revocation. I also understand that you may decline to treat or continue to treat me after I am revoked my *Consent.*

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.