SALMONS FAMILY DENTISTRY
4329 BALL CAMP PIKE, KNOXIVLLE, TN 37921 865-521-7707

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

You may refuse to sign this acknowledgement

CONSENT TO DISCLOSE HEALTHCARE IN ORDER TO TREAT PATIENT:

NAME OF PATIENT GIVING CONSENT:____

Address:____

Home Phone: ______________________________ **Cell Phone:** ___________________________________

Email: _____________________________________ **Social Security Number** _________________________

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 is posted in our Reception Room and on our website. 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 by printing from our Website, or asking our receptionist at the front desk, or contact Anita Barker or Susan Wood at 865-521-7707 or email office@salmonsdds.com.

ASSIGNING SOMEONE FOR US TO DISCUSS YOUR TREATMENT WITH:

By signing this form I give permission to discuss my treatment, payment activities and healthcare operations with the below mentioned persons:

1. ____
   NAME, ADDRESS, AND PHONE #

2. ____
   NAME, ADDRESS, AND PHONE #

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.
Completed Consent will be scanned into patient's chart

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.

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)