Deborah Ann Conner, DDS, PLLC

practice limited to endodontics

Consent for Use and Disclosure of Health Information

Section A: Patient Providing Consent

Name: _____

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 options.

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 of Privacy Practices 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 revisions, by contacting:

Tricia Santos, Practice Manager
Phone: 919 416 4200 Fax: 919 416 4230 email: tricia@debconnerdds.com
Address: PO Box 2565, Durham, NC 27715
Website: https://www.debconnerdds.com/p-patient-forms.html

Right to Revoke: You 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 effect any action we took in reliance on this Consent before we received your written revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Section C: Signature

I, _____, have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand 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 _____

Please complete the following if this Consent is signed by a personal representative on behalf of the patient:

Personal Representative's name: _____Relationship to patient: _____

You are entitled to a copy of this Consent after you sign it.