RELEASE OF RECORDS

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION.

SECTION A: PATIENT GIVING CONSENT

Name:

Address:

Phone Number:

Email:

Social Security Number: _______-______-______

SECTION B: TO THE PATIENT **(Please read carefully.)**

Purpose of Consent: By signing this form, you will consent to the 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 form. 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. We encourage you to read 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 policy, we will issue a revised “Notice of Privacy Practices”. 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:

Daniel Charlton, DDS

P: (858)481-8848

Fax: (858)369-5445

E: frontdelmarviewdental@gmail.com

13983 Mango Dr, #101i,

Del Mar, CA, 92014

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 note that revocation of this consent will not affect any action we took in reliance on this consent before receiving your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

SIGNATURE

I, ____ **(printed)**, 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 this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name **(printed)**:

____

Relationship to PT:

____

Signature:

____

Date:

____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Signature

____