

# Long Island Family Dental, PC

931 Walt Whitman Rd/Rte.110 Melville, NY 11747

## Consent for Use and Disclosure of Health Information

### Section A: Patient Giving Consent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Social Security #: \_\_\_\_\_

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 our treatment, payment activities, and healthcare operations, of uses and disclosures we may make or your protected health information, and of other important matters about your protected health information. A copy of our notice is available at the front desk for you to review. 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 revision of Notice, at any time by contacting:

Contact person: Connie Ursich

Telephone: (631)423-5200

Fax: (631)423-5216

Address: Long Island Family Dental, PC

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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 receive your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

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 you use and disclosure of my protected health information to carry out treatment, payment activities and health care operation.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_