Patient Name: _____
Last First MI

LE CENTER
Dental Clinic

Date of Birth: ____ / ____ / _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

If you wish to provide another person access to this patient's treatment, financial, or appointment records, please complete this section.

(Note: Parents of minors are implied and therefore do not need to be listed. If utilizing insurance and the policy holder is not the patient, the policy holder must be listed and given access to financial information.)

Name of Party: _____ Relationship: _____
Given access to: O Medical Information O Financial Information O Appointment/Scheduling

Name of Party: _____ Relationship: _____
Given access to: O Medical Information O Financial Information O Appointment/Scheduling

Name of Party: _____ Relationship: _____
Given access to: O Medical Information O Financial Information O Appointment/Scheduling

Consent for Use and Disclosure of Health Information

Purpose of Consent: By signing this form you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practice: 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 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 Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Dr. Jill McMillen, D.D.S.
Telephone: 507-357-4982
Address: 101 S. Park Avenue, Le Center, MN 56057

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

I have had full opportunity to read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I give my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

X Signature: _____ Date: _____

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

Representative's Name: _____ Relationship to Patient: _____

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