GREGORY DENTAL GROUP

Consent for Use and Disclosure of Protected Health Information

I,_____, hereby state that by signing this consent acknowledge and agree as follows:

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. I understand that this consent if valid for seven years.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide 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 health information. 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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

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 received your revocation, and we may decline to treat you or continue treating you if you revoke this consent.

Communication-I understand that and consent to the following appointment reminders or communications that will be used by the practice- A postcard mailed to me at the address provided, telephone call to my preferred number and/or leaving a message on my answering machine or with the individual answering the phone. An automated text message reminder to the cell number provided.

Preferred Method of Contact:

- ○ Home Phone
- ○ Cell Phone
- ○ Text Message
- ○ Email

Persons Other Than Patient Authorized To Receive Protected Health Information

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I have had a full opportunity to read and consider the contents of this consent form and your notice of privacy practices. I understand that by signing the 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 NAME_____
RELATIONSHIP TO PATIENT_____
** YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN **

You may obtain a copy of our Privacy Notice, including any revisions by contacting:
Sierra Welsh – Office Manager Phone 615-444-0322 Fax 615-444-0325
gregorydentalgroup@gmail.com 1430 Baddour Pkwy Ste B Lebanon, TN 37087