MARK • A • TROMBLAY • DMD • PC

JOHNATHAN • A • SLATE • DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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. You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this Consent. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our contact person. The revocation will not affect any action we took in reliance on the Consent before we received your revocation, and that we my decline to treat you or to continue treating you if you revoke 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 that will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, __________________________,

1) have had time to fully read and consider the contents of the Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent, 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.

2) acknowledge receipt of **Notice of Privacy Practices**.

3) consent to electronic communications by text and/or email.

Signature: ____ Date: ____________________

Personal Representative and Relationship:____________________________ Date: ____________________

You may obtain a copy of your Notice of Privacy Practices, including revisions by contacting:

Mark A Tromblay, DMD
Johnathan A Slate, DMD
Phone: 202-331-1554 or FAX: 202-331-9627
E-mail: info@mstreetdental.com

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

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign. ___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement. ___ Other (Please Specify): ________________________

Signature: ____ Date:________________________

REVOCATION OF CONSENT:

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: _________________________

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