# Park 56 Dental Group

## HEALTH INSURANCE AND PORTABILITY ACT OF 1996

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**Revised 07/30/04**

**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 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 is available upon request. 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.
- **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 below. 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 that we may *refuse* to treat you or to continue treating you if you revoke this Consent. Please ask for the signature form to revoke your consent.

You may obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

Park 56 Dental Group
120 East 56th Street Suite 610, New York, NY 10022
(212) 826-2322

**SIGNATURE**

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 your use and disclosure of my protected health information to carry out treatment; payment activities and heath care operations.

*Name:*______________________________________________________________________

*Signature:* ____________________________________________*Date:* _________________________