CONSENT OF DISCLOSURE

(For the Usage and or Disclosure of Protected Health Information)

I hereby give consent to **COVE CHOICE DENTAL** to use and disclose my protected health information for the purpose of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed and delivered to the address below. You may deliver this in person or by mail but it will only be effective when we receive it.

You have the right to request restriction on the usage and disclosure of your health information for the purpose of treatment, payment or health care operations. We are not required to grant your request, however if we do, the restriction will be obligatory to us.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure for your protected health information. You have the right to review our Posted Privacy Policy before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy be requesting the front desk staff.

HIPPA ACKNOWLEDGE

I have had an opportunity to review the Notice of Privacy Practices.

Print Name of Patient * _____

Signature _____ Date _____

If you are going to sign as the patient's representative:

Print your Name _____

Relationship _____

Welcome and thank you for letting us care for your smile!

COVE
ChoiceDental

When quality and comfort matter, the CHOICE is simple.