Pioneer Valley Dental Arts
Consent For Use And Disclosure Of Health Information

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 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 our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Anna Connor by phone at 413-567-4227 or in writing at 171 Dwight Road, Suite 200, Longmeadow, MA 01106.

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 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 this Consent form and your Notice of Privacy Practices. I have received a copy of your Notice of Privacy Practices and 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 healthcare operations.

I hereby authorize the following person(s) to act on my behalf and I consent to the release and disclosure of my protected health information to them:

____ ______________________________________
Name Relationship

____ ______________________________________
Name Relationship

____ ______________________________________
Name Relationship

I also give permission to leave messages at **my** following telephone numbers:

_______________________________________ [ ] Home [ ] Work [ ] Cell

_______________________________________ [ ] Home [ ] Work [ ] Cell

Signature: ____ Date: ______/______/______

Print Name: ____

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

Patient's Name: ____

Relationship to Patient: ____

You are entitled to a copy of this consent after you sign it.