Goldsboro Dental Arts
Shaun White, DMD

Consent for Use and Disclosure of Health Info & Notice of Privacy Practices

Name: _____

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 info to carry out treatment, payment activities, & health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sing this consent form. Or notice describes the ways in which we may use your protected health info. We reserve the right to change our privacy practices as described in the Notice, If we institute changes, we will have a revised version of the notice. If you wish to obtain a copy of our Notice of Privacy Practices, you may ask the receptionist at the front desk for a copy, call us anytime (919)-581-0909, or mail a writing request to Shaun White at 1310-C Wayne Memorial Dr. Goldsboro, NC 27534. For your convenience, we have posted a summery of this info (titled "Privacy and Your Health Info") on the wall in the reception area.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your reception to the front desk. Please understand that revocation of the Consent will not affect any action we took in reliance of this consent before we received your revocation, and that we may decide to treat you or continue treating you if you decide to revoke the Consent.

Please Sign here:

I, _____, have had the full opportunity to read and consider the contents of this form and your Notice of Privacy Practices. I understand that by signing this form, I am giving my consent to your use and disclosure of my health info as described above.

Signature: _____ Date: _____

If this consent is being signed by a reversative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relation to patient: _____