

Lykins Family Dentistry
60 Highland Ct., Suite 202
East Ellijay, GA 30540
706-698-3384

HIPPA Consent for use and disclosure of Health Information

Section A: Patient giving consent

Name: _____

Address: _____

Telephone: _____

DOB: _____ Social Security#: _____

Section B: To the patient. Please read

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 accompanies this consent. We encourage you to read it carefully before signing.

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 changes.

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

Contact Person: Teresa Hughes or Sandy Bielefeldt
Telephone: 706-698-3384

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 health care operations.

Signature: _____ Date _____

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

Personal Rep Name: _____

Relationship to Patient: _____

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_____