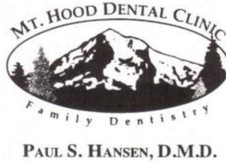

Mt Hood Dental Clinic – Paul S. Hansen D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I,______________________________________ have received a copy of this Office's Notice of Privacy Practices. By signing this form, I acknowledge receiving it and do consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you sign this consent form. A copy of our Notice accompanies this form; we encourage you to read it carefully and completely before signing this consent.

You have the right to revoke this consent at any time by giving us written notice. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to continue treating you.

Signature_____________________________________date____________________________

If parent or guardian relationship to patient____