ACKNOWLEDGEMENT OF RECEIPT OF NOTICE & CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION OF THE PRIVACY PRACTICES FOR:

ALAN K.NEAL, DMD, PC

(You may refuse to sign this acknowledgement)

Please read carefully.

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 other important matters about your 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 your protected health information that we maintain.

You may obtain a Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Alan K. Neal, DMD, PC at (503)266-2705 or fax the request to (503) 266-2973.

Right to revoke: You may have the right to revoke this Consent at any time by giving us written notice of revocation submitted to the Contact Person or his/her representative. Please understand this will affect any action we took in reliance to 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 been offered a copy of this office's Notice of Privacy Practices, and have had full opportunity to read and consider the contents of their Consent and the Notice of Privacy Practices. I understand that, by signing this Consent, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

_____

Signature *Date*

Consent given for myself and the following family members that are under the age of 18:

_____

Minors' names

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship of Patient: _____

If you would like to opt out of us using your information for fundraising and marketing, please, initial here____.

Communication Release Authorization

I, _____ _____give permission to Alan K. Neal, DMD, PC to share my dental needs, conditions, treatment, radiographs, and financial information regarding my treatment with the following people:

Name: _____Relationship:_____Contact Number: _____

Name: _____Relationship:_____Contact Number: _____

Patient Signature: _____Date:_____

NEAL FAMILY DENTAL