Claremont Design Dentistry

Consent of Disclosure

I hereby give to Claremont Design Dentistry to use disclose my protected health information for the purpose of treatment, insurance billing, insurance and patient payment and health care operations. You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and it will only be effective when we actually receive it. Your cancelation will not be effective to the extent that we or others have acted in reliance upon request of this consent. You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us. Our posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our posted Privacy Policy before you sign this consent.

Print Name of Patient _____

Address of Patient _____

Telephone ( ) _____

Acknowledgement of Receipt of Privacy Practices Notice

I, _____, acknowledge that I have received a Notice of Privacy Practices from Claremont Design Dentistry.

Signature _____ Date _____

If personal representation signs this authorization on behalf of the individual, complete the following.

Personal Representative's Name: _____

Relationship to Individual: _____

Cancellation

I hereby void the consent given above.

Signature of Patient: _____ Date _____

Witness:

Signature _____ Date _____