



CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

You May Refuse to Sign This Acknowledgment.

I have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Relation to Patient: _____

Signature: _____ Date: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our Privacy Official. Please understand that revocation of this Consent will not affect any action we took in reliance on 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.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Reproduction of this material by dentists and their staff is permitted. Any other use, duplication or distribution by any other party requires the prior written approval of the American Dental Association. This material is educational only, does not constitute legal advice, and covers only federal, not state, law. Changes in applicable laws or regulations may require revision. Dentists should contact their personal attorneys for legal advice pertaining to HIPAA compliance, the HITECH Act, and the U.S.

Department of Health and Human Services rules and regulations. © 2010, 2013 American Dental Association. All Rights Reserved.