Consent for Use and Disclosure of Health Information

Print Name____ Date of Birth________________________________

PLEASE READ THE FOLLOWING STATEMENTS 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 of other important matters about your protected health information. We encourage you to read our Notice of Privacy Practices carefully and completely before signing this consent.
- You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

  HillView Dental
  2535 S. Lewis Way Ste 109
  Lakewood, CO 80227
  303-985-9850

- We reserve the right to change our privacy practices as described in our Notice of Privacy Practices: We will issue a revised Notice of Privacy Practices, which will contain those changes. Those changes may apply to any of your protected health information that we maintain.

- 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 the office listed above. Please understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that we may decline to treat your or to continue treating you if you revoke this consent.
- 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 that 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.

Please list any persons, along with their phone numbers that you wish to have access to your account: (All areas of account will be accessible, unless documented below)

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Signature____ Date______________________________________
If not Patient, Print name and Relation____