TEXAS KIDS DENTAL CARE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patients Name _____ Date of Birth: _____

Address _____

City/Zip _____

Telephone _____ Work Phone _____

SECTION B: TO THE PATIENT-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

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 any of your protected health information that we maintain

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting.

Contact Person **HIPPA PRIVACY OFFICER**

Telephone. **(915)858-6868** Fax: **(915)858-6878**

Address **9411 Alameda Ste P. El Paso TX 79907**

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 Contact Person listed above 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

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, 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

Signature _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.