Consent for Use and Disclosure of Health Information

Patient's Name Giving Consent: _____

Purpose of this consent:

By signing this form, you will be consenting to our use and disclosure of your protected health information to:

Carry out treatment
Payment activities
Healthcare operations

Our Notice of Privacy Practices 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.

Right to Review Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. A copy of our Notice of Privacy Practices accompanies this consent. We encourage you to read it carefully and completely before signing this consent.
You may obtain a copy of this consent form or revised form at any time by contacting:

Contact Person: Mehran Enayati DDS
Telephone: 503-533-8240 Fax: 503-533-8320
Email: smile@bethanydental.com
Address: 15280 NW Central Drive Suite 201 Portland, Oregon 97229

Changes to Privacy Notice:

We reserve the right to change the terms of the Privacy Notice.

Right to request restrictions:

You have a right to request restrictions on the use and disclosure of you health information. If Dr. Enayati agrees to a restriction, he will agree to restrict use and disclosure as was requested. Dr. Enayati is not required to agree to any restriction requested.

Right to refuse:

You have the right to refuse to sign this consent. If you refuse to sign this consent, Dr. Enayati will not provide you with treatment until you consent.

Right to revoke:

You 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.

Effective Period:

This consent is good unless and until you withdraw it in writing.

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 use your disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal representatives name: _____
Relationship to patient: _____

Signature: _____ **Date:** _____

You are entitled to a copy of this consent after you sign it.