Andrew M. Alpert, DMD, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: Patient giving consent

Name ____

Address____

Telephone ______________________________ E-mail ___________________________

Social Security Number ___________________

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. In addition, you will be giving us permission to utilize your health information including x-rays and photographs for teaching and publication purposes. We will not disclose your identity when using this information. If for some reason we wish to use your identity, we will request am additional consent for this purpose.

NOTICE OF PRIVACY POLICIES: 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. We encourage you to read it carefully before signing this contract.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practice we will issue a revised notice 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 at any time by contacting our office at 2999 NE 191st Street Concorde Centre II Suite 708 Aventura, Florida 33180. Telephone, 305-935-0122 or periofrontdesk@bellsouth.net.

Right to Revoke: You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to our office 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.

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 ______________________________

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

Personal Representative's Name____

Relationship to Patient____