Hamann Dentistry

ACKNOWLEDGEMENT AND CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

NAME:________________________________

Birthdate:____________________________

SECTION B TO THE PATIENT PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

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, Healthcare Operations, Subpoenas, Immunization Information, Notice of Privacy Practices, Minnesota Healthcare Bill of Rights, Workers Compensation, Patient Access, Minors, Provider to Provider and Communication in the form of telephone, cell, email and text.

PURPOSE OF ACKNOWLEDGEMENT: By signing this form you acknowledge you had the opportunity to read our Notice of Privacy Act for Hamann Dentistry. 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 Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting.

Contact Person: Dr Brooke Hamann
Telephone: 218-346-4775
Address: 200 First Ave S Perham MN 56573

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 revoke this Consent.

Signature: ____________________________ Date: ____________________

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

Personal Representative's Name: ____________________________

Relationship to Patient: ____________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
INCLUDE COMPLETED CONSENT IN THE PATIENT'S CHART.