Dean Brewer DDS
Amanda Brewer DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name_____

Address_____

Telephone_____Email_____

Patient #_____SS #_____

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

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 revision of our Notice at any time by contacting:

Contact Person: Jamie Van Laar
Telephone: 209-578-0707 Fax: 209-578-1016
Address: 1213 Coffee Rd Suite H Modesto Ca 95355

Right to Revoke: You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that 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 our treatment, payment activities and healthcare operations.

Signature: _____Date:_____

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

Personal Representative's Name_____

Relationship to patient_____