HIPAA Consent Form

I hereby give consent to Reed Family Dental to use and disclose my protected health information for the purpose of treatment, payment and health care operations. I have also received, read and understand my copy of Dr. Reed's Notice of Privacy Act for the Dental Practice.

You may cancel consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail. It will only be effective when we actually receive it. Your cancellation will not be effective to the extent that other or we have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purpose of treatment, payment and health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted privacy policy provides more detailed information about the usage and disclosure of your protect health information. You have the right to review our posted privacy policy before you sign this consent.

We reserved the right to terms of our posted privacy policy. You may obtain a copy of the current policy by contacting our office at 229 S 4th St, Coshocton, OH 43812.

Print name of patient _____

Signature of patient _____ Date _____

If you are signing as the Patient's Representative:

Print your name _____

Relationship _____

Cancellation

I hereby void the consent given above.

Print name of patient _____

Signature of patient _____ Date _____

If you are signing as the Patient's Representative:

Print your name _____

Relationship _____

Address for cancellations: **229 S 4th St, Coshocton, OH 43812**

*Your cancellation will be effective upon receipt at the above address.