

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

By signing below I state that I have read and received a copy of the Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact Cheryl Gard. You may reach her by contacting:

Practice Name: James J. Yount, D.D.S.
Telephone Number: (937) 372-9631
Address: 462 North Detroit Street
City, State, Zip: Xenia, Ohio 45385

Patient's Consent

_____ Name:
_____ Address:
_____ City: _____
State: _____ Zip: _____
_____ Telephone: ()

I, _____, have read and received the Notice of Privacy Policies and I consent to the use of my PHI for the purposes of healthcare operations, treatment and payment activities.

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:

The following people are able to obtain information regarding my private health information:

_____ relation _____ relation _____
_____ relation _____ relation _____