William B. Munn, D.D.S.

3890 Old Williamsburg Road, Sandston, VA 23150
Tel: 804-328-2200 • Fax: 804-328-0528

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____

Patient Number/Social Security Number:_____

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 protected health information to carry out treatment, payment activities, and healthcare operations which may include, scheduling appointments, detailed correspondence by phone or mail and calling you by name.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices in our office 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 can accompany this Consent, upon your request. 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 post 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 revisions of our Notice, at any time by contacting:

Telephone: 804-328-2200 Fax: 804-328-0528

Address: 3980 Old Williamsburg Road, Sandston, VA 23150

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 you revoke this Consent.

Special Permission

The office of Dr. William B. Munn D.D.S., has my permission to share my protected health information with the following (who would not be given this information without patient's written consent) to carry out treatment, payment activities, and healthcare operations which may include, scheduling appointments, detailed correspondence by phone.

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 out treatment, payment activities and health care operations.

Signature: _____ Date: _____

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

OR

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.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. **I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.**

Signature: _____ Date: _____