Consent For Use and Disclosure of Health Information

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. 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 description of our treatment, payment activities and healthcare operations, of the uses and disclosure 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 consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our 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. 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.

*Notice of Privacy Practices is displayed in the waiting area at all MAK Dental Group locations.

Signature____ **Relationship to Patient** ____________________________

I give MAK Dental Group permission to disclose information to the following individuals (Please list their name and phone number)

SELF ONLY

Spouse ____

Parents ____

Child ____

Guardian ____

Personal Friend ____

Signature____

Relationship to Patient __________________________________

Emailing X-Rays

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialist or dentists. This allows the other provider to have a better diagnostic tool available to them which could cost you less and permit you to have access to quicker service. I understand the x-rays might need to be emailed to other specialists and dentist. I give my permission for this service.

Signature________________ ________________________

Relationship to Patient ___________________________

MAK DENTAL GROUP