SOUTHERN DENTAL ASSOCIATES, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT INFORMATION:

Name: _____

Address: _____City/St/Zip: _____

Telephone: _____Email: _____

Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing the form, you will consent to our use and disclosure of your protected health information to carry out the treatment, payment activities, and healthcare operations. If you are a parent/guardian filling the form out on behalf of someone else, this consent applies to the patient.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide 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 the Notice can be found in the waiting area for you to review before signing the 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 revisions of our Notice, at any time by contacting:

Contact Person: Dana White
Telephone: 850-477-5252 ● Fax: 850-477-5532
Emails: c.t@ctdentistry.gccoxmail.com or info@mysoutherndental.com
Address: 151 West Airport Boulevard ● Pensacola, FL 32505

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.

SIGNATURE OF PATIENT or parent/guardian:

I, _____ (***please print name)*** 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 is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

◯ Individual refused to sign
◯ An emergency situation prevented us from obtaining acknowledgement
◯ Communications barriers prohibited obtaining acknowledgment
◯ Other (Please specify)