OXLER FAMILY DENTISTRY

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

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
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.

You have the right to read our Notice of Privacy Practices 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 accompanies this Consent. We encourage you to read it 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, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

RIGHT TO REVOKE: You have the right to revoke this Consent at any time by giving us written notice. 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 refuse to treat you or to continue treating you if you revoke this Consent.

PATIENT NAME AND ADDRESS ____
(PLEASE PRINT)

____

PRINT NAME 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. I acknowledge that I have received a copy of your Notice of Privacy Policy.

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: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
You may obtain a copy of our notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our current Privacy Officer by phone at 722-2596, by fax at 722-3486, or by mail at 900 N. Tyler #2, Wichita KS 67212.
CONCERNS, QUESTIONS, or COMPLAINTS should also be directed to our Privacy Officer.

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FOR OFFICE USE ONLY
We attempted to obtain written consent for use and disclosure of health information and acknowledgement of receipt of our Notice of Privacy Practices, but were unable to because:

_____Individual refused to sign
_____Communication barriers prohibited obtaining consent acknowledgement
_____An emergency situation prevented us from obtaining consent and acknowledgement
_____Other (please specify)____