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.
Before signing, please read our Notice of Privacy Policies to gain clear understanding of how we may use and disclose your PHI.
For questions concerning our Notice of Privacy Policies, please contact:
Atlantic Dental by phone 602-923-0700, fax 602-923-0800 or at 3229 E. Greenway Rd., Ste 103, Phoenix, AZ 85032.

Patient Consent

Name: ..... City: .....

Address: ..... State: ..... Zip: .....

Telephone: ..... Social Security #: .....

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

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

Personal Representative's Name: .....
Relationship to Patient: .....
Signature: .....

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior action while acting under your consent.

Signature: ..... Date: .....
If this consent revocation is signed by a personal representation on behalf of the patient, complete the following:
Personal Representative's Name: .....
Relationship To Patient: .....