

**PALM VALLEY ORAL & MAXILLOFACIAL SURGERY
CONSENT FOR USE and DISCLOSURE OF HEALTH
INFORMATION**

Section A: Patient (or representative) giving this Consent:

Patient Name: _____

Name of Parent or Guardian (if patient is a minor) _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Work: _____ Cell: _____

Circle the **best** phone # at which to contact you: Home Work Cell

Email address: _____

Social Security #: _____

Section B: To the Patient – 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 treatments, payment activities, and healthcare operations.

Notice of Privacy Practices: You have had the right to read our Notice of Privacy Practices before you decided 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.

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 revisions of our Notice at anytime by contacting:

Sandi Steele, Office Manager

Telephone: 623-935-5774

Palm Valley OMFS

1646 N. Litchfield Rd. Suite 130

Fax: 623-935-6524

Goodyear AZ 85395

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 healthcare operations.

Signature: _____

Date: _____

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

Name: _____

Relationship to patient: _____

You are entitled to a copy of this consent after you sign it.