1420 E. McAndrews Rd
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SUMMIT
FAMILY DENTAL CARE

office@summitdmd.com
541-779-2634

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
Medical Information Release Form
(HIPPA Release Form)

Name: _____ **Date of Birth: _____/____/_____**

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 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 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 by contacting:
Contact: Rachelle Brown at Telephone: 541.779.2634 Fax: 541.779.3282
Email: office@summitdmd.com Address: 1420 E. McAndrews Medford, OR 97504

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. Release of Information will remain in effect until terminated by me in writing

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:
[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

Messages
Please call [ ] my home [ ] my work [ ] my cell Number:_____
If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

I have had full opportunity to read and consider the contents of this Consent form and you 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 have been offered and/ or received a copy of this office's Notice of Privacy Practices.

Print Name: _____ Signature: _____ Date: _____

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

Name:_____ Relationship: _____Date: ___/____/_____