

## HIPAA Disclosure

### 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 you 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, including any revisions of our Notice, at any time by contacting:

Contact Person: Gregory S. Glavan, DDS

Telephone: (763) 276-1410

Fax: (763) 276-1411

Address: 405 Babcock Boulevard East, Ste. 130 Delano, MN 55328

### Consent of Privacy:

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.

### Revocation of Consent:

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health-care operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

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

Signature: \_\_\_\_\_

Response Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_