

**SOUTHDALE PERIODONTICS**

**CONSENT FOR USE AND DISCLOSURE OF  
HEALTH INFORMATION**

**NAME:** \_\_\_\_\_

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our practice. (via e-mail, phone and the USPS)

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting our office at (952) 922-6949.

Right to Revoke: You will have the right to revoke this consent at any time by giving us a written notice of revocation submitted to the office manager, Cher Doty. 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 or to continue treating you if you revoke this consent.

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.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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

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**PERMISSION TO DISCUSS MEDICAL CARE  
(OPTIONAL)**

I hereby give permission to discuss my medical treatment, medications, and/or financial information with the following individual: (This must include translators)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone # \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_