CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

NAME: ____

SOCIAL SECURITY # ____

Section B: To the Patient – Please 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 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.

The Smile Shack has adopted a (**Breach Notification Policy and Procedures Program**) pursuant to HITECH (Health Information Technology for Economic and Clinical Health Act) of the American Recovery and Reinvestment Act of 2009 and the rules and regulations issued by the U.S. Department of Health and Human Services ("HHS"). The purpose of the program is to detect possible breaches of PHI (Personal Health Information), conduct a risk assessment to determine whether a breach or unsecured PHI (Personal Health Information) has occurred, and provide any required notification. This program must be observed by all employees, agents, and independent contractors of this practice, including the professional, administrative, and clerical staff (the "workforce").

You may obtain a copy of our Notice of Privacy Practices including any revisions of our notice at any time by contacting The Smile Shack at 740-454-4112.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation and submitting it to the Smile Shack. 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.

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:** __________________________

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

Personal Representative: ____

Relationship to patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.