Consent for Use and Disclosure
Of Health Information

Purpose: In cases where Dr. Demetrick LeCorn D.M.D., M.S. has been directed not to rely on acknowledgement as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payments activities, and healthcare operations, as more fully in our Notice of Privacy Practices.

Section A: patient giving consent

Patient Name: _____

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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Bobbi Jo LeCorn

Office Number: 352-291-9360 **2130 SW 22nd Place #101**

Fax: 352-291-9363 **Ocala, FL 34474**

Right to Revoke: You will have the right to revoke the 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 have taken 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 Authorize _____ (Referring Dentist) To receive a copy of my dental treatment report.

Additional Person(s) Authorized to receive dental treatment report _____
Relationship: _____

Signature: 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 options.

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

Personal Representative's Name: _____ Relationship: _____

Signature: _____ Date: _____