AS4U0716- HIPAA - CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

A Smile 4 U Cartersville
509 N Tennessee St Ste 107
Cartersville, GA 30120

Ph : (770) 407-8700
Email: as4u_cv@asmile4u.com

Cora Neese
12 Russle Ridge
Euharlee, GA 30145

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Please read the following statements:

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 Joint Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and 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. You are entitled to a copy of this form if you would like one…just ask.

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 Joint 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 Joint Notice of Privacy Practices, including any revision of our notice, at any time by requesting a copy at:
A Smile 4U, LLC
HIPAA
366 N. Main Street, Suite 300
Alpharetta, GA 30009

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 address listed above. Please understand that revocation of the consent will not affect any action we took in reliance of this consent before receiving your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I have had full opportunity to read and consider the contents of this consent form and A Smile 4U, LLC Joint Notice of Privacy Practice. I am giving my consent to A Smile 4U, LLC use and disclosure of my protected health care information to carry out treatment, payment activities, healthcare operations and other uses described in the A Smile 4U, LLC Joint Notice of Privacy Practice that was provided to me.

Patient Signature: _____

Parent/Legal Guardian Signature: _____
(if patient is a minor under the age of 18)