# Legendary Smiles

## Consent for Use and Disclosure of Health information

Name: _____Phone#:_____
Address: _____
Date of Birth: _____SSN:_____

I am requesting Legendary Smiles to send the following information_____
_____.
Address: _____.

This request will remain in effect for one year from the _____day of _____20____.

**TO THE PATIENT (please read the following statement carefully)**
**Purpose of consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities and health care 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 health care operations, of the uses and disclosures we may make of 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 practice at any time including any revisions of our Notice by contacting Legendary Smiles by mail PO Box 486, Watford City, ND 58854, by telephone at 701-842-4474 or by fax at 701-842-4472.

**Right to Revoke:** You will have the right to revoke 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 took in reliance of this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke consent.

**SIGNATURE:**
I _____, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use of disclosure of my protected health information to carry out treatment, payment activities and health care operations.
Signature_____Date_____