CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

BY SIGNING THIS FORM YOU AUTHORIZE FIANT DENTAL TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES AND HEALTHCARE OPERATIONS.

SECTION A: PATIENT INFORMATION

Full Legal Name: ______________________________ SSN: ____________________

Address: ____

City, State, Zip: ______________________________ Phone Number: ______________

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent form. 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 Fiant Dental's present and past Notice of Privacy Practices documents by contacting:

Fiant Dental
3225 Lyndale Avenue South
Minneapolis, MN 55408

Right to Revoke: You have the right to revoke this Consent at any time by sending written notice to the above address. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation. Also, Fiant Dental may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: AUTHORIZATION

I have fully read and considered the contents of this Consent form and Fiant Dental's Notice of Privacy Practices. I give my consent to Fiant Dental to use and disclose my protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: ______________________________ DATE: ____________________

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

PERSONAL REPRESENTATIVE NAME: ____

RELATIONSHIP TO PATIENT: ____

fiant dental