CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
JUSTIN BEASLEY, D.D.S.

Patient Giving Consent:

Name _____

Address_____

Telephone_____E-mail _____

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 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. A current Notice of Privacy Practices can be found online at www.DrJBeasley.com.

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

Dr. Justin Beasley
4600 West Memorial Rd, Oklahoma City, OK 73142
405-755-5400, Fax: 405-755-8484
justin@drjbeasley.com

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 person listed above. 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, (PRINT NAME) _____, 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.

Patient or Guardian Name Printed Date

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

Personal Representative's Name:_____

Relationship to Patient: _____

If you would like to give us permission to discuss your dental treatment or account information with any family members, please list them here:

Office Use Only

We attempted to obtain written acknowledgement of receipt or our Notice of Privacy Practices and Consent for Use and Disclosure of Health Information, but could not be obtained because: _____