

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SECTION A: PATIENT GIVING CONSENT	
NAME:	
Purpose of Consent: By signing you consent to our use and disclosu Health Information to carry out treatment, payment activities, and hea	
Notice of Privacy Practices: You have a right to read our Privacy Practopy of our Notice accompanies this consent form. You may obtain a Privacy Practices by contacting:	
Judith Chandran (402) 957-2193 19060 Q Street, Suite #106 Omaha, NE 68135 Or visit our website: <a href="www.Springhilldentalomaha.com">www.Springhilldentalomaha.com</a> Right to Revoke: You have the right to revoke this consent at any time notice to the contact person above.	ne by giving written
I,	have had the
opportunity to read and consider the contents of this Consent and No	otice of Privacy Practices
<u>X</u> Signature: Date:	
If this Consent is signed by a personal representative of the patient, pfollowing:	please complete the
Personal Representative's Name:	
Relationship to Patient:	

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM