William S. Lenihan III D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT (MANDATORY)

Name: _____ Social Security #_____

Address: _____

Telephone: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to perform or facilitate treatment, payment activities, healthcare operations, lawful demands from government officials, or national security. A copy of our Notice of Privacy Practices accompanies this Consent. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Please read it carefully and completely before signing this consent.

Use of protected health information includes copies of exams, medical tests, photographs and x-rays performed at other medical/dental offices. This consent includes requesting needed information from your health care professionals and giving requested information to your health care professionals.

You have the right to revoke this Consent at any time by giving us written notice or signing the Revocation section below.

I, _____, 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, health care operations, lawful demands, or national security.

Signature: _____ Date:_____

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

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. _____ Initials

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

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

Contact Person: Deanna Hutcheson or Dr. Bill Lenihan
Telephone: (865) 482-1731 Fax: (865) 482-4821
Address: 400 Laboratory Rd. Suite 104 Oak Ridge, TN 37830

Revised 4/3/09