

Dr. William S. Wooten, DDS, PA

**CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

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

Purpose of Consent: By signing this form, you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities (including filing insurance), and healthcare operations.

Notice of Privacy Practices: By signing this form, you acknowledge receiving a copy of the Notice of Privacy Practices that gives a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

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.

To obtain more information regarding our privacy practices you may contact: Pam Weldon at: (252)492-5200. Address: 857 S. Beckford Dr., Henderson, NC 27536.

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.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices of which I have received a copy. I understand that, by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a person representative or parent/guardian on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____