Brian Bird DMD & Robert Hendricks DDS

Name:_____ Date:_____

-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY-

Purpose of Consent: By signing the 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 Practice: 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. 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 is available. 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, 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 the Privacy Notice, including any revisions of our Notice at any time by contacting: ***Bird Family Dental Care 208-322-1263 1744 N Mitchell St, ID 83704***

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 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 revocations, and that we may decline to treat you or to continue treating you if you revoke this consent.

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

Signature: _____ ***Date:*** _____

Personal Representative:_____***Relationship***:_____

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

Personal Health Information Disclosure Agreement

I,_____, do hereby grant permission for Bird Family Dental Care (Brian Bird DMD and associates), to disclose my personal health information to the following personal representative(spouse, child, friend, etc.)_____

Information to be disclosed (Please Check All That Apply):

___Appt ___Financial/Billing Info ___Treatment/Referrals ___Dental Ins

I understand that this permission remains in effect unless a written cancellation had been provided to Bird Family Dental Care:

Signature:_____ ***Date:***_____