VALLEY DENTAL GROUP

CONSENT FOR USE OR DISCLOURE OF INFORMATION

FOR PURPOSES REQUESTED BY

VALLEY DENTAL GROUP

I hereby permit Valley Dental Group to use my health information, and / or to disclose my health information to any third party payor, or to any party involved in my health care.

I understand that there is a Notice of Privacy Practice posted in the office available for me to read.

This consent shall be in force and effect as long as I am a patient in this practice.

I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my doctor at this practice.

I understand that information used or disclosed pursuant to this consent may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.

Refused to sign the consent form.

_____

Signature of patient or personal representative and date

_____

Name of the patient or personal representative (Please PRINT)

_____

Description of personal representative authority