MORRIS PERIODONTICS

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

Purpose of Consent: By signing this form, you will acknowledge receipt of this office's Notice of Privacy Practices and you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You may refuse to sign this consent.

TO THE INDIVIDUAL: Please read the following and complete the information requested.

Effect of Declining Consent : This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to treat you.

Privacy Practices Notice: You have the right to read our Privacy Practices Notice before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and health care operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. 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 Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Contact Office: Morris Periodontics
613 SE 5th St., Lee's Summit, MO 64063
Telephone: (816) 554-2663 Fax: (816) 554-2664 E-mail: info@morrisperio.com

INDIVIDUAL'S SIGNATURE

I, ____, have had full opportunity to read and consider the contents of this consent. I understand that, by signing this form, I am confirming that I have received a copy of this office's Notice of Privacy Practices and am giving my written permission for the disclosure of my protected health information, as described in this form.

Signature: ____ Date: _____________________

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

Personal Representative's Name:____

Relationship to Individual: ____

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. 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: _____________________