



## Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

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**Patient Name**

**Date**

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Summit Family Dental may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Summit Family Dental has a detailed document called the “Notice of Privacy Practices”. It contains a more complete description of our rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the “Notice” before signing this agreement. If I ask, Summit Family Dental they will provide me with the most current Notice of Privacy Practices.

My signature below indicates that I have been given the chance to review such copy of the Notice of Privacy Practices. My signature means that I agree to allow Summit Family Dental to use and disclose my protected health information to carry out treatment, payment and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Sundance Dental Care has taken action relying on this consent.

I give permission to the following people to access my records: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature (Patient or Legal Custodian/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (if signed by another party)

\_\_\_\_\_  
Date

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our “Notice” at any time by contacting Summit Family Dental of Cortez, 111 Sligo, Building A, Cortez, Colorado 81321 (970) 459-1314