# JONES FAMILY DENTISTRY
## Scott L. Jones, D. D. S.

# WRITTEN ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

**Name (Printed)**______________________________ **Social Security**__________________

**Address:** ________________________ **City/State**__________________ **Zip**________

**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 your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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 operation, of 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 your Notice is posted in the office. You may request a copy of our Notice. 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Or ask the receptionist.

**Contact Person:** Michele Jones or Teresa DuBose Telephone: 281-592-1500 Fax 281-592-6700
Address: 208 East Houston St., Cleveland, Texas 77327

Your 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. (Ask for Right to Revoke Form.)

## SIGNATURE

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

**By signing below, you acknowledge receiving a copy of Jones Family Dentistry's Notice of Privacy Practices.**

**Signature of Patient** ____________________________ **Date:**____________

*If this Consent is signed by a personal representative on behalf of the patient, complete the following:*

**Representative's Name (Printed):**______________________________

**Relationship to Patient (Printed):** ______________________________

**Signature of Representative:**________________________ **Date:** ____________

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT IF YOU REQUEST IT**