Central Park South
SMILE DESIGN

DANIEL JACOBS DMD FAGD
30 Central Park South, Suite 7C
New York, NY 10019
P-212-755-3473 **F**-212-755-2055
info@CPSsmiledesign.com

Consent For Use and Disclosure of Health Information

Section A: Patient Giving Consent

Name _____
Address _____
Telephone _____ E-mail _____
Patient #_____ Social Security# _____

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, payments activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read out 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, of the use and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of this Notice accompanies this Consent. We encourage you 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 privacy practices, we will issue a revised Notice of Privacy Practices, which will certain 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:
Office Manager: Odette Colon
Telephone: 212-755-3473
E-mail: info@cpssmiledesign.com
Address: 30 Central Park South Suite 7c New York, New York 10019

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contract Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I have had full opportunity to read and consider contents of this Consent form 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.

Signature_____ **Date**_____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to patient: _____