DENTAL CARE OF SALINA
DR JASON WELLS DDS
DR ALISON RIEKHOF DDS
700 S Front St Salina KS 67401
785-825-6211

Section A: Patient giving consent
Name_____ SS#_____
Address_____
Telephone:_____ E-mail_____

Section B: To the Patient- **PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.**
PURPOSE OF CONSENT: By signing this form, you will consent to our use & disclosure of our protected health information to carry out treatment, payment activities, & 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 operations, of the uses & disclosures we may make of your protected health information, & of other important matters about you protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing.
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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 of copy at any time by contacting:
Contact Person: Jason Wells D.D.S.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of you revocation submitted to the Contact Person listed above. Please understand that revocation will *NOT* affect any action we took in reliance on this Consent before we received you revocation, & that we may decline to treat you if you revoke this consent.

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

Signature:_____ Date:_____
If this Consent is signed by a personal representative of the patient, complete the following: Representative's Name:_____
Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include complete Consent in the patient's chart

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 or continue to treat me after I have revoked my consent.
Signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
"You May Refuse to Sign This Acknowledgement."

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print name

_____
Signature

_____
Date signed

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barrier prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

_____

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