CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF CONSENT:
By signing this form, you consent for the office of **Rodney E. Shivers, D.D.S.** to use and disclose your health information for treatment, health care operations and payment activities. We may provide this information to a physician, healthcare facility, or to obtain payment from your insurance carrier. The **Notice of Privacy Practices** has been provided to you for review and you may request a copy at any time. Please read it carefully before signing this consent form.

RIGHT TO REVOKE:
You have the right to revoke this consent at any time by giving written notice of your revocation to the office manager of this practice. Please understand that revocation of this consent will not affect any disclosure or action taken prior to your request for revocation.

I have had full opportunity to read and consider the contents of the **Notice of Privacy Practices for Protected Health Information (HIPPA)**. I understand that in signing this form, I am giving consent to use and disclose my protected health information to carry out treatment, health care operations and obtain payment as described.

_____ _____
(SIGNATURE) (DATE)

NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

***IF SIGNING AS A PATIENT REPRESENTATIVE, PLEASE COMPLETE THE FOLLOWING**:

REPRESENTATIVE'S NAME_____CONTACT#:_____

RELATIONSHIP TO PATIENT_____