GentleDental
OF SILOAM SPRINGS

Consent for Use and Disclosure of Health Information

Notice of Privacy Practices: You have the right to read our Notice Of Privacy Practices Our notice provides a description of our treatment, payment activities, and healthcare operations with the uses and disclosures we may make on your behalf using your protected health information.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager of Gentle Dental of Siloam Springs
Telephone: (479) 524-6182 Fax: (479) 549-3399
Address: PO Box 582, Siloam Springs, AR 72761

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.

Signature: I have had full opportunity to read and consider the 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.

Authorization: My health records are private and are known under the law as "Protected Health Information (PHI)". By completing and signing this form, I, or my legal representative, have given Gentle Dental authorization to share my PHI with the individuals or companies listed below. This includes Gentle Dental's subsidiaries, affiliates, employees, agents and subcontractors.

PLEASE LIST ANY PERSONS YOU WISH TO HAVE ACCESS TO YOUR ACCOUNT:

_____ _____

_____ _____

SIGNATURE: _____ **DATE:** _____

If not the Patient, Please Print Name and Relation: _____

Consent for Use and Disclosure of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by Gentle Dental of Siloam Springs. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPPA privacy regulations.
Purpose: The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising.
Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practices. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed. **PHOTOS & Videos will NEVER be taken nor used without your permission!**

Patient Name: _____ Date: _____
If Patient is a Minor:
Parent/Legal Guardian: _____

SIGNATURE: _____