SMILE SAVERS OF LAUREL, LLC
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form you will consent 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 operations of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. You may request a copy of this Notice after 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 contain.

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

Smile Savers of Laurel, LLC
Dr. Ingrid M. Thompson, D.D.S.
8377 Cherry Lane
Laurel, MD 20707
(301) 362-9700 phone (301) 362-4306 fax

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice for 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 the Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent. This form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

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 healthcare operations.

PERSON GIVING CONSENT

Name:____

Address:____

Telephone:______________________________________ **Date:**_____________

This Consent was signed by: * ____