UNIVERSITY SQUARE DENTAL ASSOCIATES
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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: *Patient Giving Consent*
Name: _____ Social Security Number: _____
Address: _____
Telephone: _____ Email: _____

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, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent Form. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent Form. We encourage you to read it carefully and completely before signing this form.

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

Contact Officer: Minerva Echevarria
Telephone: (215) 662-1030
Fax: (215) 662-1015
Address: 3901 Market Street, Box 1936, Philadelphia, PA 19104

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation to the contact person listed above. Please understand the revocation of this Consent will not affect any action we took in reliance on this Consent before we received 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 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 you to use and disclose my protected health information to carry out treatment, payment activities and health care options.

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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT