Randall H. Hiers, D.D.S., P.A.
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________ **Date of Birth:** ______________________

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 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before 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 maintain.

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

Eastern Shore Smile Solutions

Location: 17 Franklin Street, Cambridge, MD 21613 or 29276 Erickson Drive, Easton, MD 21601

Telephone: 410-228-4191 Fax: 877-712-4781

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. Please understand that 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, the below signed patient, 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.

Signature: ____ **Date:** ____________________

IF YOU WOULD LIKE A COPY OF THIS FORM AFTER YOU SIGN IT, PLEASE NOTIFY A MEMBER OF OUR STAFF.

SECTION C: SPEAKING WITH OTHERS (Although **OPTIONAL** must be complete in order to discuss information with anyone other than the patient)

I permit Eastern Shore Smile Solutions, their dentists, clinical staff members, and business staff to discuss my dental health information and treatment, in person or by telephone or written treatment plans and estimates, with the following members involved in my care:

Name	Phone	Relationship

This authorization is limited to the following timeframe from __/__/__ to __/__/__. If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want communication between Eastern Shore Smile Solutions dentists, clinical staff members, business staff and any of the individuals named above, I must notify Eastern Shore Smile Solutions.

Patient's Signature: ________________________ **Date:** ________________________________

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: ________________________________

Relationship to Patient: ________________________________