CHANDLER CREEK
DENTAL CARE

2200 N AW Grimes Blvd, Suite 100
Round Rock, TX 78665-0000

HIPPA Consent Information

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.

If we obtain or create information about your health, we are required by the law to protect the privacy of your information. Protected health information (PHI) includes any information that relates to:

- Your past, present, or future physical or mental health or condition;
- Health care provided to you.
- Past, present, or future payment for your health/dental care.

Notice of Privacy Practice: 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. We may share your PHI through approved, secure electronic methods for the purpose of treatment, payment for health care services, or health care operations such as case management or care coordination. We may also need to share your PHI electronically for public health purposes such as preventing and controlling the spread of infectious diseases or for certain disaster relief efforts.

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.

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 to treat you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and the 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.

If this consent is signed by a personal representative, parent or guardian on behalf of the patient, complete the following:

Patient/Representative signature: _____ Date:_____