ASIM R. ZAIDI DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT CONSENT

NAME _____

ADDRESS _____

TELEPHONE _____

E-MAIL _____

TO THE PATIENT – PLEASE READ 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.

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 pertain to any of your protected health information that we maintain.

You may obtain a copy of our notice of privacy practices, including revisions at any time by contacting Asim R. Zaidi, DMD 429 Highway 35 Red Bank NJ 07701 732-345-8460.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. 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, _____ have had full opportunity to read and consider the contents of this consent form. I understand that by signing this 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: _____