American Dental Care
Aicha Lyazidi, D.D.S
105 N Virginia Ave Suite 103
Falls Church VA 22046

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

Social Security Number: _____

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 operation.

Notice of Privacy Practices: you have the right to read our Notice of Privacy 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 or our Notices, at any time by Contacting:

Contact Person: Aicha Lyazidi
Telephone: 703-533-7285 Fax: 703-533-7287
Address: 105 N Virginia Ave suite 103
Falls Church, VA 22046

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 of you revoke this consent.

SIGNATURE

I, _____, have had full opportunity to read the contents of this consent from and you're 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.

Signature **X** _____ Date: _____

I give consent to discuss my medical treatment with:
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's notice of Privacy Practices.

_____
(Patient Signature)

_____
(Please Print Patient Name)

_____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt or our Privacy Practices,
But Acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ an emergency prevented us from obtaining acknowledgement
___ Other (please Specify)

_____
_____
_____