Dr. David R. Winchester, D.M.D., P.C.
Consent for Use and Disclosure of Healthcare Information

SECTION A: PATIENT GIVES CONSENT (Please Print Here)

NAME ____

ADDRESS ____

PHONE ______________________ EMAIL: ____

PATIENT NUMBER ______________________ SOCIAL SECURITY NUMBER _____________________

SECTION B: TO THE PATIENT--PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form,you 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. 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 and/or personal information, and of other important matters about your protected information. A copy of our Notice is available on our website and a hard-copy is available to you at our office. We encourage you to read our Notice carefully and completely before signing this consent 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, containing the changes. Those changes may apply to any of your protected healthcare and/or personal information that we maintain.

You may obtain a copy of our work notice of privacy practices including any revisions of our notice and any attempt either of our website or by contacting:

Contact person: Tabby E. Winchester
Phone: 205-854-7448 **FAX:** 205-854-7462
EMail: HIPAA@DrDavidWinchester.Com
Address: 2500 Center Point Parkway, Suite 100, Birmingham, AL 35215

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 already taken in reliance on his consent before we received your revocation, and that we might decline to treat you or to continue treating you if you revoke his consent.

Signature

I, ____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Policy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected healthcare and/or personal information to carry out treatment, payment activites, healthcare operations, etc. as described in your Notice of Privacy Policies.

Signature: ____ Date: ______________________________

If signed by a personal representative on behalf of the patient, please, complete the following:

Personal Representative's Name ____

Relationship to the Patient: ____