CHDA

Cherry Hills
Dental Associates, P.C.

FAMILY COSMETIC AND IMPLANT DENTISTRY

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PRIVACY CONSENT

This form is **required**, by the new patient privacy regulations recently issued, by the ***United States Department of Health and Human Services***. Prior to commencing your dental treatment, you muct review, sign, and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation, and licensure).

You have the right to review our office's privacy notice prior to signing this Consent, a copy which you were given with this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required, and may not honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes. The changes may not be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation.

_______________________________________ ________________

Patient's or Guardian's Signature Date

Other Family Members:

__________________________ __________________________

__________________________ __________________________

__________________________ __________________________

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