

Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact:

Dr Lazarow's Team - You may reach us at 1-330-644-0633.

Patient's Consent

Name: _____

Address: _____

City, State Zip: _____

Telephone: (_____) _____

I, _____, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

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

Personal Representative's Name: _____

Relationship to Patient: _____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However, by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____

Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Policies

I, _____, have received a copy of

ROBERT M. LAZAROW, D.D.S.

_____ 's Notice of Privacy Policies.

Name (print)

Signature

Date

OFFICE USE ONLY

On _____, an *Acknowledgment of Receipt of Notice of Privacy Policies* form was delivered. The form was not signed due to:

- Communication barriers which prevent acknowledgement
- An emergency which prevent acknowledgement
- A refusal to sign
- Other _____