Richard J. Gross, D.D.S.

Consent for Use and Disclosure of Health Information
HIPPA Notice of Privacy Practices

We believe that your health, dental and insurance information is personal. We keep records of care and services that you receive at our office. We are committed to keeping your information private, and we are also required by law to respect your confidentiality. If you are under 18, a parent or guardian must sign for you and handle your privacy rights.

* We will use your information, which you have supplied us for the following purposes:
* To provide the best possible treatments you require
* To request payments from your insurance carriers
* To contact you regarding your appointments and co-ordination of appointments with other health care providers.

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone:_____ E-mail:_____

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 operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign the 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 encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as describes in our Notice of privacy Practices. If we change or 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 of our notice, at any time by contacting:

Contact Person: Richard J. Gross

Telephone: 440-248-4100 Fax: 440-248-4130

Address: 34501 Aurora Road, Suite #303, Solon, Ohio 44139

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 the consent *will not* affect any action we took in reliance on this consent before we receive your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

PRINT NAME

I,_____, have had full opportunity to read and consider the contents of this Consent form and your 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 health care operations.

Signature:_____ Date:_____

If a personal representative on behalf of the patient signs this consent, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT