Mark J. Johnson, DDS, PA

CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address:_____

Ph #: (_____)-_____   Email: _____

Patient #: _____   Social Security #: _____

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 this Consent. Our Notice provides a description of our treatment, payment activities, 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 those 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:
Dr. Mark J. Johnson, DDS, PA
600 France Ave S. #310
Edina, MN 55435
Ph: 953-941-1911 Fax: 952-922-8780
www.markjjohnsondds.com

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 recovation 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 if you revoke this Consent.

SIGNATURE
I, _____, have had full oppourtunity to read and consider the contents of this Consent forma 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 this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative Name: _____
Relationship to the Patient: _____