CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name _____ Social Security #_____

Address _____ Telephone _____

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

Purpose of content: 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 sing this

Consent our Notice provides a description of our treatment, payment actives, and healthcare operation of the uses and disclosures we may make of your protected health information, and other important matter about your protected 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 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__**Dr. Jeffery Dolberry_ D.D.S**_____

Telephone_____**(901)794-8211____Fax (901)5092370**_____

Email _____**info@generationalsmiles.com**_____

Address __**6825 Winchester Rd. Ste 1A Memphis TN 38115**___

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 we took in reliance on this consent before we received your revocation, and that we may decline continued treating you if you revoke this Consent.

I, _____. Have had full opportunity to read and consider the consents of this consent from and your Notice of Privacy Practices, I understand that, by signing this consent form, I am giving my consent to your use disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature_____ Date_____

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

Personal Representative's Name_____

Relationship to Patient _____

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

Included completed consent in the Patient's chart.