Taos Dental Group
Justin Nylund, D.D.S.
Walter Jakiela, D.D.S. M.A.G.D.
C. Tom Simms, D.D.S.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: ____

Patient Birth Date: _____________________________________

Purpose of Consent: By signing this form, you will consent to use and disclose 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 to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice can be requested by you at the front desk.

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.

Contact Person: Justin Nylund, D.D.S.   (575) 758-8654

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 the 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 to treat you or continue treating you if you revoke this Consent.

I, ____, have had full opportunity to read and consider the contents of this Consent form and 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 healthcare operations.

____   __________________
Signature of patient or patient representative/parent   Date

____
Printed name of patient or patient representative/parent

____
Relationship to patient

HIPAA-ACKNOWLEDGEMENT OF RECIEPT
Notice of Privacy Practices

I, ____, have received a copy of this office's Notice of Privacy Practices.

____   __________________
Signature of patient or patient representative/parent   Date

____
Printed name of patient or patient representative/parent

____
Relationship to patient