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Patient Consent for Use of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The policy is located under the television on the wall.

By signing this form, you are consenting to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent in writing; however, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient signature_____

Relationship to Patient (if other than patient):_____

Date_____

Witness_____