

FEDERAL REGULATIONS NOW REQUIRE THIS FORM

CONSENT OF DISCLOSURE

(For the usage and/or Disclosure of protected Health Information)

I hereby give consent to Northwest Dental Services and all staff members within Northwest Dental Services facilities to use and disclose my protected health information for the purpose of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

CANCELLATION FORM AVAILABLE BY REQUEST!

You have the right to request restriction on the usage and disclosure of your protected health information for the purpose of treatment, payment and health care operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy before you sign the consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy our current policy by:

Request in writing. We will mail it to you within 10 days of receiving a written request.

Print Name of Patient _____

Sign _____ Date _____

If you are signing as the patients representative:

Relationship _____

Print your name _____

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