GLENN L. SANDS DDS
COSMETIC AND FAMILY DENTISTRY

Consent for Use and Disclosure of Personal Health Information

This form authorizes our office to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment, and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your protected health information. For further questions concerning our policies, please contact the office manager.

Name (Print) _____ Date _____

Signature _____

If this consent is signed by a personal representative on behalf of the patient, please complete the following:

Representative's Name _____ Relationship _____

I authorize my provider to disclose my private information to the extent necessary to help with my dental care and/or payment for my dental care to the entity indentified below:

Recipient Name _____Relationship _____

Address _____

City_____ State_____ Zip Code_____

Telephone _____

I understand that:

- This authorization remains in effect from the date signed
- I may inspect and/or copy the private health information to be disclosed
- I may revoke this authorization at any time in writing by contacting your office

Patient's Consent _____ Date _____