

**CLARKSTOWN DENTAL, PLLC**  
**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

**SECTION A: PATIENT GIVING CONSENT**

Name: \_\_\_\_\_

**SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS**

**Purpose of Consent:** 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 sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health 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. Jonathan Torma

Telephone: (845) 634-8111

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

**HIPPA Authorization:**

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. The Federal Law prohibits any staff member of Clarkstown Dental, PLLC from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. *Should you wish to update the names you provided below, please ask the receptionist for a HIPPA form.*

Name of individual (please print)

Relationship to Patient

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES**

*\*You May Refuse To Sign This Acknowledgement\**

I, \_\_\_\_\_, have received a copy of this office's *Notice of Privacy Practices*.

Please Print Patient's Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**FOR OFFICE USE ONLY**

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We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices* but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify):

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