Consent For Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PH) for the purpose of healthcare operators, 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 Notice of Privacy Policies, please contact:
Office Manager (435) 882-3700 or writing to: Clair R. Vernon, D.M.D.
271 South Main Street
Tooele, Utah 84074

Patient Consent

Name _____ Social Security _____

Address _____

City _____ State _____ Zip_____

Telephone (___)_____ E-mail _____

I _____ have read your Notice of Privacy Policies and I consent to
(Patient Name)
your use of my personal health information for the purposes of healthcare operations, treatment and payment activities.

Signature _____ Date _____

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

Personal Representative _____ Date _____
Relationship to Patient _____

Acknowledgment of Receipt of Notice of Privacy Policies

I hereby acknowledge that I have received a copy of the Notices of Privacy Practices.

_____ Date _____
Signature