



MARNIE C. BAUER, D.M.D.
General and Cosmetic Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient-giving consent

Name: _____

Address: _____

Telephone: _____

Section B: To the patient - PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

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 Consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of 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 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 the office Dr. Marnie C. Bauer.

Town and Country Office
7926 W. Hillsborough Ave. Suite B
Tampa, FL 33615
(813) 886-5653

West Tampa Office
4306 W. Kensington Ave.
Tampa, FL 33629
(813) 839-2273

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact listed above. Please understand that by revocation of this Consent will affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____