Harold Howell, III D.M.D.
CONSENT FOR USE AND DISCLOURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: ______________________________ Address: ______________________________

Telephone: __________________________ Email: ________________________________

Social Security Number: __________________________

Section B: **PLEASE READ THE FOLLOWING STATEMENTS 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 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.

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 Michele Linville Telephone: 304-369-2034 Fax: 304-369-3086 Email: drhowell@email.com or snail mail: 407 State Street Madison, WV 25130.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted tot he contact person listed above. Please understand that revocation of this consent will not 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.

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

Signature________________________________ Date____________________________

SIGN BELOW ONLY IF YOU DO NOT GIVE PERMISION TO RELEASE INFORMATION
I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may declined to treat or continue to treat me after I have evoked my consent.

Signature _____________________________ ___ Date____________________________

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