# Consent for Use and Disclosure of Health Information

# Healthy Young Smiles

**Section A: Parent giving consent for minor or patient if under the age of 18.**

Patient Name:_____

Address: _____

Telephone: _____ E-Mail: _____

**Section B: To the parent or patient over the age of 18, 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 disclosure 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. A copy of our notice accompanies the 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 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 anytime by contacting:

**Melanie Gill**
**610-524-9085**
**479 Thomas Jones Way, Suite 400**
**Exton, PA 19341**

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice to the contact person listed above. Please understand that the 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 treatment if you deny this consent.

I have had the full opportunity to read and consider all the 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.

Name: _____ Date: _____

Signature: _____