Patient Forms

Consent For Use & Disclose Of Health Information

SHARADA KACHAM D.M.D.

CONSENT FOR USE AND DISCLOSE OF HEALTH INFORMATION
SECTION A: PATIENT GIVING CONSENT (Please Print)

Name: _____

Address: _____

Telephone: _____ Cell Phone: _____

Email: _____ Social Security #: _____

PLEASE READ THE FOLLOWING INFORMATION STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry our treatment, payment activities and health care operations. Notice of Privacy Practices: You have the right to read or Notice of Privacy Practices before you decide to sign this consent. Our notice provides a description of our treatment, payment activities and health care operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this consent. You may obtain a copy of our Notice of Privacy Practices including revisions by contacting:

SMILES
General & Cosmetic Dentistry
Sharada Kacham, D.M.D., P.A.
4600 Military Trail, Ste 219
Jupiter, FL 33458 (561) 844-0715

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.

SIGNATURE: _____ DATE: _____