CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

JERRY P. KATZ D.D.S. F.A.G.D.

Purpose of Consent: By signing this form, you will consent to our use 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 activity, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters. 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 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:

Jerry P. Katz, D.D.S., F.A.G.D.
3818 Spicewood Springs Rd., Suite 200
Austin, TX 78759
Office (512) 343-0033 Fax (512) 343-2859
jerry.katz@att.net

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 person listed above. Please understand that revocation of this consent will not affect any action that we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices, and have had full opportunity to read and consider the contents. 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 this treatment, payment activity and health care operations.

Signature: _____ Date: _____

Print Name:_____

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

Personal Representatives name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.