Cornerstone Dental

John D. Beckwith, D.M.D

Cosmetic & Implant
Dentistry for Adults and Children

- Implant Evaluation and Treatment
- Root Canal Therapy
- Non-Surgical Periodontal Treatment
- Crown, Bridge, Dentures
- Cosmetic Bleaching
- Bonding
- Porcelain Crowns and Veneer
- Orthodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: ______________________________

Address: ______________________________

Telephone: ______________ E-mail: ______________

Patient Number: ______________ Social Security Number: ______________

SECTION B: TO THE PATIENT –PLEASE READ AND FOLLOW STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form you will consent to our use and disclosure of you 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 disclosure we may make of your protected health information, and or 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 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:

Contact Person: Johnna Araneo, Office Manager
Telephone: (908) 359-2121 Fax: (908) 359-4344
E mail: jdbdmd@yahoo.com
Address: 485 Amwell Road Hillsborough, NJ 08844

Right to Revoke: You will have to right to revoke this Consent at any time by giving us written notice of your revocation submitted 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 of to continue treating you if you revoke this Consent.

I, ______________________________, have had the 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 healthcare 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: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

Revocation of Consent

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 decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: ____________________