

Dr. Dawn Morehead DDS, PA

**CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS**

The Patient hereby consent to the use or disclosure of his/her individually identifiable health information ("protected health information") by Dr. Dawn Morehead DDS, PA in order to carry out treatment, payment, or health care operations . The Patient has reviewed this Office's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and have the right to review such Notice prior to signing this consent form.

This Office reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If this Office does change the terms of its Notice of Privacy Practices, I may obtain a copy of the revised Notice [by following this procedure].

Patient retains the right to request that this Office further restrict how Patient's protected health information is used or disclosed to carry out treatment, payment, or health care operations. This Office is not required to agree to such requested restrictions; however, if this Office does agree to my requested restriction(s), such restrictions are then binding on Office.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to this Office in writing. The revocation shall be effective *except* to the extent that this Office has already taken action in reliance on the Consent.

This Office may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that this Office is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, this Office has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that this Office is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time _____ AM/PM

Signature of Patient or Legal Guardian

Please print name

Dr. Dawn Morehead
127 E. Elm Ave.
Wake Forest, NC 27587
(919)556-0444
Fax (919)554-9010
www.Dawnmorehead.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the **Notice of Privacy Practices** of this office.

Signature: _____ Date: _____

Please Note: It is your right to refuse to sign this acknowledgement.

Office Use Only

We tried to obtain written acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

An emergency prevented us from obtaining acknowledgement.

A communication barrier prevented us from obtaining acknowledgement.

The individual was unwilling to sign.

Other: