Fatemeh Taher , D.D.S

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

*** You may refuse to sign this acknowledgement***

TO THE PATIENT: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND COMPLETELY.

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 Consent; You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. Our notice provides a description of the uses and disclosures we may make of your protected health information in involvement with treatments, payment activities, healthcare operations, or other important issues. A copy of our notice accompanies this consent form.

We reserve the right to change our privacy practices, as described in our Notice of Privacy Practices. If any changes are made, we will issue you a revised Notice of Privacy Practices. Changes may apply to any of your protected health information that we may obtain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our notice, at any time by contacting:

Dr. Fatemeh Taher
Telephone: 678-215-1300 Fax: 678-407-4850 Email: **Dr.** **Taher_Staff@yahoo.com**

Address: 3370 Sugarloaf Pkwy, Suite G-8 Lawrenceville, GA 30044

Right to Revoke: You have the right to revoke this consent at any time by giving us a written notice of your revocation and submitting it to the contact person listed below. Please understand that revocation of this consent will not affect any action taken in reliance of this consent before the receival of your revocation. However, we may decline to treat you or to continue treating you if you revoke this consent form.

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, payment activities, and healthcare operations.

_____ _____
Print Name Date

_____
Signature

*If a personal representative on behalf of the patient signs this consent, please complete the following:
Personal representative Name: _____
Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT ONCE SIGNED