SEDRO-WOOLLEY FAMILY DENTAL CENTER
830 METCALF STREET
SEDRO-WOOLLEY, WASHINGTON, 98284
Telephone (360) 855-0351

SEDRO-WOOLLEY FAMILY DENTAL CENTER
Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purpose of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact the office manager at (360) 855-0351.

Patient's Consent

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Telephone: (_____) _____

I have read your Notice of Privacy Policies and I consent to your use of my PHI for the purpose of healthcare operations, treatment and payment activities.

Signature: _____ **Date:** _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

Patient's Revocation

By signing below, you revoke your above consent for us to use and disclose your PHI. However by doing so, we reserve the right to discontinue treatment for you. This revocation also does not negate any of our prior actions while acting under your consent.

Signature: _____ **Date:** _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

ATTENTION: PLEASE TURN OVER TO COMPLETE THE REVERSE SIDE OF THIS FORM.