LAWSON
family dental

2395 Troop Drive, Suite #101 | Sartell, Minnesota 56377
320.252.6191 | www.lawsonfamilydental.com

Consent for Use and Disclosure of Health Information

By signing this form, you allow us to use/disclose information necessary to carry out treatment, payment, and healthcare operations.

You have the right to read our Privacy Practices Notice and keep a copy *(available in our office).*

We reserve the right to change our Privacy Practices and, if done, we will issue a new Privacy Practice Notice.

You have the right to revoke this consent at anytime in writing. We may decline to treat you if you revoke this consent.

I, _____ , allow Lawson Family Dental, P.A. to use/disclose my personal health information to carry out treatment, payment activities, and health care operations related to my account.

I also understand that Lawson Family Dental, P.A. submits information to my insurance company *(where applicable)* as a service to me, but ultimately it is my responsibility to know my insurance policies/ practices and to make payment for any portion the insurance does not pay.

All payment is due upon completion of treatment unless otherwise arranged.

I have read and understand the above:

Signature_____

Date _____ On behalf of _____

Revocation of Consent:

I revoke consent for use and disclosure of my personal health information for treatment, payment, and health care activities.

Signature_____

Date _____