# Zysik Family Dental

Edmund T. Zysik Jr. DDS
67 East Orvis Street
Massena, NY 13662

***HIPAA*** - Consent for use and disclosure of health information:

**Section A: Giving Consent**
**Patient Name**_____
**Address**_____
**Telephone**_____
**Social Security#**_____

**Section B: To the Patient- Please read the following statements carefully**:

**Purpose of consent:** By signing this consent 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 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 of other important matters about your protected health information.

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 anytime by contacting:

**Jamie or Ann** - 764-1867
67 East Orvis Street, Massena, NY 13662

**Right to Revoke:** You will have the 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 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 or to continue treating you if you revoke this Consent.

**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 Dr. Edmund T. Zysik Jr. for the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations as he deems appropriate.

**I give consent to speak with** _____**relationship**_____
**I give consent to speak with** _____**relationship**_____
Regarding any treatment that I may need or any account information that may be needed

**Date** _____.