Wilmington
Dental Studio
Dr. Abrahamian & Dr. Orchanian

Consent for Use & Disclosure

PATIENT INFORMATION

First Name		Last Name				Birth Date	
Address		City		State		ZIP Code	

SECTION B: TO THE PATIENT (OR ADULT GUARDIAN)

Please read the following statements carefully

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 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 disclosures we may make of your protected health information, and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 any time, by contacting:

Email: mary@wilmingtondds.com
Telephone: (978) 938-4188

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 office manager at Wilmington Dental Studio. 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.

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 health care operations.

FORM COMPLETION

SIGNATURE OF:	☐ PATIENT ☐ LEGAL GUARDIAN	☐ PARENT ☐ AGENT UNDER DURABLE POWER OF ATTORNEY	
PRINTED NAME	*First Name*	*Last Name*	
SIGNATURE		DATE	