Bellbrook *Neighborhood Dental* **CONSENT**

Consent for Use and Disclosure of Personal Health Information

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

By signing below, I state that I have read and received a copy of the 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 Cheryl Gard at:

Practice Name:	William C. Dahling, DDS
Telephone Number:	937-848-6511
Address:	1964 N. Lakeman Drive
City, State, Zip:	Bellbrook Ohio 45305

Patient's Consent	If minor or POA, Custodial Consent
Name: ______________________________	Name: ______________________________
Address: ____________________________	Address: ____________________________
____________________________________	____________________________________
Telephone: __________________________	Telephone: __________________________

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

New: 9-12-11