

**CONSENT FOR USE AND DISCLOSURE OF
PERSONAL HEALTH INFORMATION**

This form authorizes us to use and disclose protected health information (PHI) for the purposes 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 protected health information.

For further questions concerning our Notice of Privacy Policies, please contact:

Office manager-Carolyn B. – you may reach us by calling 801-446-8007 or writing to Little People’s Dental at 1268 West South Jordan Parkway, Suite 101, South Jordan, Utah 84095.

CONSENT

Patient’s Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ 2nd # to reach you: _____

****E-mail:** _____ (for
confirmation of appointments)

I, _____, have read your Notice of Privacy
(Patient’s Guardian)

Policies and I consent to your use of our personal health information for the purposes of healthcare operations, treatment and payment activities.

Signature: _____ **Date:** _____

Relationship to Patient: _____

****Acknowledgement of Receipt of**
Notice of Privacy Policies**

I hereby acknowledge that I have received a copy of Little People’s Dental Notice of Privacy Policies.

Name (print)

Date: _____

Signature