Dr. John D. Stockman D.D.S. PA 2051 S. Greenhouse Rd. Suite 200 Houston, TX 77084

Phone: 281-463-0339 Email: jdstockmandds@gmail.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name: _____

Social Security #: _____

Address: _____

Telephone: _____

Email: _____

SECTION B: TO THE PATIENT- 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: Your have the right to read our Notice of Privacy Practices before you decide whether or not 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 protected 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 otain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the office at 281-463-0339.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. 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 operations.

Signature: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action the office of Dr. John D. Stockman, DDS, PA took in reliance on my Consent before the office received this written Notice of Revocation. I also understand that the office of Dr. John D. Stockman, DDS, PA may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____