



# Dr. Joseph Sachs & Associates

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### SECTION: A PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

### SECTION: B TO THE PATIENT READ THE FOLLOWING STATEMENT CAREFULLY

Purpose for 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 options.

**Notice Of Privacy Act:** You have the right to read our notice of privacy before you decide to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of our protected health information, and of other important matters about your protected health information. A copy of our notice is displayed in our patient waiting room. 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 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:

Contract Officer: Joseph Sachs DDS  
E-Mail: [drsachs@drjosephsachs.com](mailto:drsachs@drjosephsachs.com)

Telephone: 212-929-7718  
Address: 201 West 18<sup>th</sup> Street, New York, NY 10011

**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 continue treating you if you revoke this consent.

### SIGNATURE:

I \_\_\_\_\_ have had a full opportunity to read and consider the contents of this consent form and our 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_