CONSENT TO USE AND/OR DISCLOSE OF PATIENT INFORMATION

As a patient of Lyudmila Shur, D.D.S., you have the right to know how we may use and disclose information about you. Information about this is provided in our Notice of Privacy Practice.

You have the right to review our Notice of Privacy Practice before signing this form. A copy of this notice is available to you for your review at the front reception desk. We may change our Notice of Privacy Practice at any time.

We consent to use or disclose information about you so that we can provide you with health care treatment, arrange payment for your care; and conduct certain kinds of administrative health care operations. By signing this consent to use and/or disclosure of patient information, you agree that we may use or disclose information about you for these purposes.

You have a legal rights to request us not to use or disclose information about you for some kinds of treatment, payment or health care operation purposes. We are not legally required to grant this kind of request. We are only bound by a request for additional restrictions if we agree to them in writing.

By signing below you agree that we may use information about you for purposes of providing treatment, arranging payment, and health care operations.

_____

Patient name: (Please Print) Date

_____

Patient or legally authorized signature Date

_____

Printed name if signed on behalf of the patient Relationship