DWAINE E. VALENTINE, D.D.S., INC.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR DENTAL CARE OPERATIONS

I consent to Dwaine E. Valentine, D.D.S., Inc. using and disclosing my protected health information to carry out treatment, payment, or dental care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent.

I understand that Dwaine E. Valentine, D.D.S., Inc. reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by requesting a copy from the office manager.

I have the right to revoke this consent by notifying Dwaine E. Valentine, D.D.S., Inc. in writing, except to the extent that Dwaine E. Valentine, D.D.S., Inc. has taken action in reliance on my consent.

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Signature of patient or patient's representative

Date _____

Printed name of patient or patient's representative

Relationship to patient or representatives authority to act for the patient

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Printed name (if different from above)