A.I.R. Dentalplex
101 Bellevue Road, Suite 101, Pittsburgh, PA 15229-2132
Phone Number: 412-931-7900 Fax Number: 412-931-4111
Email: airdentalplex@gmail.com

Consent for Use and Disclosure of Health Information

Name: ____

Address:____

Telephone: ____

Email: ____

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: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information (PHI), and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encouraged 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 obtain a copy of our Notice of Privacy Practices, including any revisions, at any time by contacting:

Contact Officer:	**Dr. Brian A. Borodaty**
Address:	**101 Bellevue Rd, Suite 101, Pittsburgh, PA 15229-2132**
Telephone:	**412-931-7900**
Fax:	**412-931-4111**
Email:	**airdentalplex@gmail.com**

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 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 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 Privacy Practices. I understand that by signing this Consent form, I am giving my consent to use and disclosure of any PHI to carry out treatment, payment activities and healthcare operations.

____ ______________________________

PATIENT SIGNATURE DATE

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

____ ____

PERSONAL REPRESENTATIVE'S NAME RELATIONSHIP TO PATIENT