Dr. Jeffrey S. Bilotti, D.D.S., P.A.
11518 San Jose Boulevard
904-268-5600
Mercedes Bilotti, Office Manager

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION/ ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

NAME _____

ADDRESS _____

TELEPHONE _____

DATE OF BIRTH _____

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 receive and review our Notice of Privacy Practices before deciding to sign this consent. A copy of our Notice accompanies 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.

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: Mercedes Bilotti

11518 San Jose Boulevard

Jacksonville, FL 32223

(904) 268-5600

I, _____, have had full opportunity to read and consider the contents of this Consent form. I have also received a copy of 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 care operations.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____

Source of Authority _____