Lee A. Slotkin DDS
1553 Route 27, Suite 3800
Somerset, NJ 08873
732-247-5959

Consent for Use and Disclosure of Health Information

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 to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make on your protected health information, and of other important matters about your protected health information. 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 to patients, 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 practices at anytime by contacting our office.

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 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,_____(Print Name), have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices and have received a copy of this office's 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, legal guardian or parent on behalf of the patient, complete the following:

Name:_____ Relationship to Patient:_____

Authorization For Signature on File (Insurance Patients Only)

Authorization of Payment / Release of Information and Financial Responsibility

I, _____ herby authorize the office of Lee A. Slotkin, DDS to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents. I authorize payment of dental services otherwise payable to me, directly to the office of Lee A. Slotkin DDS.

I agree to be responsible for all the charges for dental services and material not paid by my dental plan unless the treating dentist or dental practice has a contractual agreement with my insurance benefits company prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize the release of any and all information relating to any and all claims for myself.

This "Signature on File" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

Today's Date:_____Signature of Insured/Patient:_____

Expiration Date:_____ Signature of Witness: _____

FOR OFFICE USE ONLY We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

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