

Robert H. DeWitt, D.D.S., P.C

Date: _____

I, _____ received the Notice of Privacy Practices. I have been informed that should I have questions regarding the Privacy Policy of Robert H. DeWitt, D.D.S. or do not understand information in the Notice that I may direct these questions to the office manager.

Signature

Date

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

Parent or representative's Name: _____

Relationship to Patient: _____

Revocation of Consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature

Date