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

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.

I AUTHORIZE THE USE/ DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW

A: Person(s) or Organization(s) authorized to receive this information:
E.G. Spouse's name and phone number, family member name and Phone Number, other

- ☐ Spouse — Name:_____ Phone:_____
- ☐ Family Members — Name:_____ Phone:_____
  Name:_____ Phone:_____
  Name:_____ Phone:_____
  Name:_____ Phone:_____
- ☐ Other — Name:_____ Phone:_____

1. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Robert H. DeWitt, D.D.S., P.C. in writing.
2. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment.
3. I may inspect or copy any information used or disclosed under this agreement.

_____ _____
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