**CONSENT FOR DISCLOSURE OF HEALTH INFORMATION**

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, Douglas P. Chang, dba DentaWorks Hawaii is required under federal law to obtain your consent. Please review this consent. If you agree with its terms, please sign and date this consent below.

Should you desire a more complete description for the permissible uses and disclosure of your protected health information, you have the right to review a Notice of Privacy Practices (The "Notice") prior to signing this consent.

By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment,
Payment or health care operations.

You have the right to request restrictions how your protected health information is used or disclosed to carry out treatment, payment or health operations. However, we are not required to agree to such restrictions. If we agree to restrictions that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.

I, _____ (name of Patient), hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between you (patient) and Dr.Douglas P. Chang D.D.S. No other individuals/organizations have permission to Obtaining my confidential information under this consent.

This consent form will be kept in your patient file for a period of six (6) years.

_____ _____

Patient Signature Date

_____

Print Name

For Dentist use only:
Date Received_____ Witness Signature_____