Monesmith & Wood Oral and Maxillofacial Surgery, P.C.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, ___________________________________, have been given and have reviewed a copy of the Monesmith & Wood's Notice of Privacy Practices. I understand that my signature on this form gives my consent for my protected health information to be used for the purposes of : **TREATMENT, PAYMENT, HEALTHCARE OPERATIONS.**

I also acknowledge with this consent, that the office of Dr.'s Monesmith & Wood may call (leaving messages on voice mail, answering machine, or in person) or mail to my home or other alternative location, any healthcare operations such as : **APPOINTMENT REMINDERS; INSURANCE ITEMS; PATIENT STATEMENTS; REQUESTS TO CONTACT THE OFFICE; INSTRUCTIONS, OR OTHER REPLIES AS REQUESTED BY THE PATIENT.**

I have the right to revoke this Consent at any time by giving written notice. I understand that revocation of this Consent will not affect any action that was previously taken in reliance of this Consent. If I refuse to sign this Consent, or later revoke it, Dr.'s Monesmith & Wood. may decline to provide treatment to me.

SIGNATURE of Patient/Parent/Guardian PRINTED Name of Patient/Parent/Guardian

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Date_____________________ Witness______________________________________

(The office of Dr.'s Monesmith & Wood reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to this office.)