tyson petersen.
DOCTOR OF DENTAL SURGERY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____, have had full opportunity to read and consider the contents of this consent form and the office's Privacy Policy. I understand that, by signing this consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations by Tyson D. Petersen DDS PLLC. My signing confirms that I have had a chance to read, review, ask questions and receive answers to my satisfaction, in regards to the office's Privacy Policy.

You have the right to read our Privacy Policy at any time. If we change our privacy practices, we will issue a revised notice of Privacy Policies, which will contain the changes. You may obtain a copy of our Privacy Policy, including any revisions, at any time by contacting our office. Should you ever choose to revoke this permission please advise our office in writing via personally delivered note or mailed letter.

_____ _____ _____
Patient Name: Signature (Patient, legal guardian or authorized agent of patient) Date:

MOBILE/ELECTRONIC COMMUNICATION CONSENT

☐ I authorize the use of my mobile phone number (listed on patient info sheet) to receive scheduling and billing messages. I agree to notify this office if my mobile number changes.

☐ I authorize the use of my email address (listed on patient info sheet) to receive scheduling and billing messages.I agree to update this office if my email address changes.

We won't sell or use this information for any other purpose other than communicating with you about your own dental appointments/billing.

_____ _____
Signature Date: