

**Campbell & Schmidt Cosmetic & Family Dentistry**  
**825 S. Waukegan Rd.**  
**Lake Forest, IL 60045**  
**847.234.4800**

**CONSENT FOR USE AND DISCLOSURE OF HEALTH  
INFORMATION**

**SECTION A : PATIENT GIVING CONSENT**

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**Name**

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**Address**

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**Telephone**

**Email Address**

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**Social Security Number**

**SECTION B: TO THE PATIENT -- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

**Purpose if Consent:** By signing this form , you will consent to our use and discloser of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices :** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice, of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Campbell & Schmidt Cosmetic & Family Dentistry  
Telephone: 847.234.4800 Fax: 847.234.4876  
Address: 825 S. Waukegan Rd., Lake Forest, IL 60045

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat or to continue treating you revoke this consent.

**SIGNATURE**

I, \_\_\_\_\_, have had full opportunity to read consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

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Signature

Date

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

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Personal Representative's Name

Relationship

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**