

**ANDREW S. CURRY, D.D.S. 4222 Texas Blvd, Texarkana, TX 75503**

I have received the Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information and have had an opportunity to read and review all contents of said document.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

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 may obtain.

You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect the action we took in reliance of this Consent before we received your revocation, and that by not signing this consent or by revoking such consent in the future, we may decline treatment.

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Printed Name

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Signature

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Date

If a personal representative on behalf of this patient signs this Consent, or is appointed by you as the patient to have shared knowledge of Treatment, Payment Activities, and Health Care Operations, please fill out the following information.

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Personal Representative's Name

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Relationship to Patient