Brian O. Coleman, D.M.D., P.A.
Ωmega Dental Group
Tangerine Professional Center
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(407) 671-1017

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Brian O. Coleman, D.M.D., P.A. (hereafter collectively referred to as "Practice") to use and disclose the entire medical record in accordance with the attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

The undersigned acknowledges that they have read and may have a copy of the Notice of Privacy Practices for Brian O. Coleman, D.M.D., P.A., **this _____ day of _____, 20__.** A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____
Please print your name

_____
Please sign your name

If you have any questions about this form or the attached Notice, please contact our privacy officer, Lynn Slivinski.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment	____
I could not communicate with the patient	____
The patient refused to sign	____
Other (please describe)	____

_____
Signature of privacy officer