PRAIRIE LAKES DENTAL- KELLY BUMGARNER DDS

CONSENT FOR DENTAL TREATMENT

I hereby give my consent for dental treatment or dental surgery to be performed, the routine treatment to consist of restoring decayed or broken teeth, extracting non restorable teeth, replacing missing teeth with prosthetic appliances, treating oral infections, pathological conditions and abnormalities by mechanical and/or chemical means. I give my consent for Prairie Lakes Dental to use local anesthetic and understand the risks and complications involved in the injection, which include: general soreness in the injection site, possible bruising, prolonged or permanent nerve damage/lip numbness and bleeding.

I also give my consent for the dentist to contact my parent(s), spouse, guardian(s), or relative(s) to obtain written consent to render any dental treatment required.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form, you will consent to our use 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 the Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies the 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 anytime by contacting: Prairie Lakes Dental: Telephone: 320-762-1717 Fax: 320-762-1715
Address: 2633 Jefferson Street, Suite 801, Alexandria, MN 56308

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 the Consent will not affect any action we took in reliance on the Consent before we received you revocation, and that we may decline to treat you or to continue treating you if you revoke the Consent.

I, ____________________________________, have had full opportunity to read and consider the contents of the 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. I am also giving my consent for treatment and disclosure

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Signature: ____**Date:** _______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: ____

Relationship to the Patient: _____________________________ **YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN**