

ASHLEY LLOYD, D.D.S., P.L.L.C.  
1330 ST. MARY'S STREET, B-30  
RALEIGH, NC 27605

## Consent for Use and Disclosure of Health Information

*Please read the following statements carefully*

**Purpose for Consent.** By signing this form you will consent to our use and disclosure for 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 healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our policy practices as described in our Notice of Privacy Practices. If changes are made you will be informed and given the new Notice. Those changes may apply to any of your protected health information that we maintain.

If you would like a copy of our Notice of Privacy Practices, including revisions, please contact Dr. Ashley Lloyd  
1330 St. Mary's Street, Suite B-30  
Raleigh, NC 27605  
919-828-1001

**Right to Revoke.** You have the right to revoke this Consent at any time by giving us written notice submitted to the contact person above. Please understand that we may decline further treatment if you revoke this Consent.

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

Patient  
Signature \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party if Minor Patient \_\_\_\_\_

Relationship to Patient \_\_\_\_\_