The Offices of

L. ALLAN PYKE, JR. D.D.S. LEONARDO J. GALLETTO, D.D.S.

1590 Medical Drive, Suite. C, Pottstown, PA 19464

1260 Valley Forge Road, Unit 112, Valley Forge, PA 19481

100 Shaeffer Street, Boyertown, PA 19512

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT, PARENT OR GUARDIAN - GIVING CONSENT

Name (Patient, parent or guardian):_____

Address: _____

Telephone: _____ E-mail: _____

Patient/Parent Social Security #: _____

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

Purpose of Consent: By signing this form, you will consent to our use and disclosure 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 healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about 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.

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 you or to continue treating you if you revoke this Consent.

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

Contact Person: Dale Barker (Dr. Galletto's office) Telephone #: 610-970-9422 Kate Strickland (Dr.Pyke's office) Telephone #: 610-323-1004

Address: 1590 Medical Dr., Ste. C, Pottstown, PA 19464 Fax #: 610-970-1244

I, (please print) _____ have had full opportunity to read and 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.

SIGNATURE : _____ / **DATE:** _____

(circle one): parent / patient / guardian

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

Include completed Consent in the patient's chart.

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L. ALLAN PYKE, JR. D.D.S. LEONARDO J. GALLETTO, D.D.S.

1590 Medical Drive, Suite. C, Pottstown, PA 19464
Dr. Pyke 610-323-1004 Dr. Galletto 610-970-9244

1260 Valley Forge Road, Unit 112, Valley Forge, PA 19481
Dr. Pyke 610-935-8433 Dr. Galletto 610-935-8599

100 Shaeffer Street, Boyertown, PA 19512
Dr. Galletto 610-369-3610

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgment *

I (patient/parent/guardian) have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature and Date _____/ _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

 Revised: 7-25-2008