# Jack F. Bickford, DDS
# Bobby T. Shirley, DMD

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given the opportunity to review the NOTICE OF PRIVACY PRACTICE prominently displayed in the lobby of this practice. I also understand a copy of this document will be provided to me at my request.

I hereby give my consent for JACK F. BICKFORD, DDS and BOBBY T. SHIRLEY, DMD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **JACK F. BICKFORD, DDS and BOBBY T. SHIRLEY, DMD MAY DECLINE TO PROVIDE TREATMENT TO ME.**

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Patient or Responsible Party Signature      Date