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PRACTICE LIMITED TO ORTHODONTICS

Consent for Use and Disclosure of Health Information

Section A: Parent/Guardian/Patient Giving Consent

Name_____
Patient Name_____
Address_____
Telephone_____Social Security#_____

Section B: To The Parent/Guardian/Patient-Please read the following carefully. Purpose of Consent: By signing this form, you will consent to our use of your/the patient's 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 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 other important matters about your protected health information. You may choose to read it in its entirety prior to signing this consent. Copies are available in this office.

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.

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 this office. 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.

Signature: I,_____have had full opportunity to read and consider the contents of this consent form and have been offered a copy of 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 healthcare operations.

Signature:_____Date_____ If this consent is signed by a parent or guardian of the patient, please complete the following:
Patient's name_____
Relationship to Patient:_____

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