CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Responsible Party: ____

Patient Name: ____

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 health care 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 health care 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.

You may obtain a copy of our Notice at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your 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 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 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: ________________

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: ______________________________

Relationship to Patient: ______________________________

COMPLETE REVERSE ONLY TO AUTHORIZE RELEASE OF RECORDS.

You are entitled to a copy of this consent after you sign it.

rev. 041210

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I request and authorize Dr. ___________________________________ and Rockwall Orthodontics to release my health care information to:

Name:____

Address:____

City, State, Zip: ____

Reason for requesting records: ____

____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

____

Or _______ All health care information Or _______ Other: ______________________________________

THIS AUTHORIZATION EXPIRES ON _______________ OR ______________ DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS: ____

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can;

- Sign and date the bottom of this form under the section labeled "Revocation of Authorization"; or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

____

Signature of patient or patient's authorized representative Date

____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

REVOCATION OF AUTHORIZATION

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: ____ Date: ________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

I , ____ , have received a copy of this office's Notice of Privacy Practices.

Please Print Name: ____

Signature: ____ Date:________________