PRIVACY CONSENT

This form is required by the patient privacy regulations issued by the United States Department of Health and Human Services. Prior to commencing your orthodontic treatment, you must review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses and demographic data) may be used in connection with your treatment, payment of your account or health care options (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's policy notice prior to signing this consent, a copy of which is available at your request.

You have the right to request restrictions on the use of your protected health information. However, we are not required to, and may not, honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes and the changes may not be implemented prior to the effective date of the revised notice.

_____

Patient/Parent's Signature

_____

Print Name

_____

Patient's Name

_____

Date