



PRIVACY CONSENT

This form is required by the new patient privacy regulations recently 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.

First, we would like to state that if you must leave our practice before orthodontic treatment is completed, a duplicate copy of your diagnostic records will be provided to you within 15 days of you signing an authorization to release these records. It is our office policy to retain the originals for our records.

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 or you account or health care operations (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our office's privacy notice prior to signing this Consent Form, a copy of which you may request along with this Consent Form.

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 our office's 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.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient's Signature (Parent if patient is a minor)

Patient's Name

Date