CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: GIVING PATIENT CONSENT

Patient Name: _____ Patient Social Security #: ____-____-_____ Patient Account #:_____

Patient Address: _____

Email: _____ Telephone #: (_____) _____ - _____

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 healthcare 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 healthcare 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 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 of Privacy Practices, including any revisions of our Notice, at any time by contacting Contact Officer:
PRIVACY OFFICER
Telephone: (407) 703-8330
Email: admin@smileconceptsortho.com
Website: www.smileconceptsortho.com
Address: 551 N. Park Ave., Ste. A, Apopka, FL 32712

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 the Privacy Officer listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on this Consent before we receive your revocation, and that we may decline to treat you if you revoke this Consent.
SIGNATURE

PRINTED NAME OF PATIENT/PARENT GUARDIAN

I, _____ have received a copy of the Notice of Privacy Practices for the above named company and had the full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am acknowledging receipt of the Notice of Privacy Practices and 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, complete the following:

Personal Representative's Name _____ Relationship to Patient _____

REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare 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 continue to treat me after that I have revoked my consent.

Signature _____ Date _____
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