

SAYRE ORTHODONTICS CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Address: _____

Phone: _____ E-mail: _____

TO THE PATIENT/GUARDIAN—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 any 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 for you to read. 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 of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Sayre Orthodontics - Phone: 406-585-1443 - **E-mail:** sayreortho@gmail.com - **Address:** 115 W. Kagy Blvd. Suite H Bozeman, MT 59715

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 / my child's protected health information to carry out treatment, payment activities and any healthcare operations.

Signature: _____ Date: _____

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

Guardian / Personal Representative's Name: _____

Relationship to Patient: _____

In addition to the authorization for release of my protected health information described above, I authorize disclosure of information regarding my account, medical conditions, treatment plan and treatment status to the following individuals:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

SIGN FOR REFUSAL OF CONSENT:

I refuse my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. Refusing to sign the acknowledgement does not prevent this office from using or disclosing health information as the rule permits it to do. I also understand that you may decline to treat or to continue to treat me after I have refused my consent.

Signature: _____ Date: _____

RIGHT TO REVOKE THIS CONSENT:

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the address listed above. 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.

Email, Text and Voice Communication Consent

Information contained in email, text and voice messages may be privileged and confidential. There is some risk that any protected health information that may be contained in such messages may be intercepted by unauthorized third parties. Our practice cannot guarantee, but will use reasonable means to, maintain security and confidentiality of messages sent and received. Sayre Orthodontics is not liable for improper disclosure of confidential information that is not caused by intentional misconduct. If you consent to conducting discussions regarding your/your child's orthodontic treatment or receiving reminders please indicate your acceptance of the risk by signing below. I have read and fully understand the communication consent and I understand the risks associated with communication between Sayre Orthodontics and me and I consent to the use of voice, email and text communication regarding the patient listed above.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT, PLEASE REQUEST IT IF YOU WOULD LIKE ONE.