SAYRE ORTHODONTICS ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND 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: By signing below, you acknowledge that you have been given the opportunity to receive a copy of our 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 acknowledge that I have had the opportunity to receive, 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 BELOW ONLY 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.*

_____ _____

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