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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient's Name ____________________

Address ____________________

Telephone ____________________ Social Security (adult) ____________________

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 (PHI) to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices, which is available to you upon request, before you decide whether to sign this consent. Our Notice provides a description of the uses and disclosures we may make of our Protected Health Information or treatment, payment activities and health care operations. 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 assure you that a revised Notice of Privacy Practices is provided for you, which will contain the changes. Those changes may apply to any of our Protected Health Information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time, including any revisions of our Notice, by contacting our protected health information coordinator at either address above.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your evocation submitted to the Contact Persons 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 your child or to continue treating you or your child if you revoke this Consent.

SIGNATURE
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 Protected Health Information to carry out treatment, pay 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: ____________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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 to continue to treat me or my child after have revoked my Consent.

Signature: ____________________ Date: ____________

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Lawton Orthodontics Notice of Privacy Practices

This notice is a summary of our Notice of Privacy Practice and describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Lawton Orthodontics, we have always kept your health information secure and confidential. The law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your or your child's file by a specialist doctor whom we may involve in your or your child's care.

- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may share your medical information with our business associates, such as a billing service . We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- We may place your photographs, newspaper articles about you, etc. on our bulletin board unless you request otherwise. No other patient information will be released in this regard.
- In an emergency, we may disclose your health information when required by Law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures of your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.
- As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files for you.
- You have the right to see and receive a copy of your health information, with a few exceptions . Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.
- You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice.
- If we change any of the details of this notice, we will notify you of the changes in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact one of our Privacy Officers shown on the reverse side of this form.
- This notice goes into effect as of April 14, 2003.

Acknowledgement

I have been offered/received a copy of Lawton Orthodontics Notice of Privacy Practices.

Signed ______________________________ Print Name ______________________________

Date ______________________________

If signing as a parent or guardian, please note the name of the patient: ______________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: __________ Initials: __________Reason: ______________________________