Patient Consent to the Use, Disclosure, and Request of Health Information for Treatment, Payment, or Healthcare Operations and Acknowledgement of the Opportunity to Read and/or Receive the Health Information Privacy Practices

Patient Name: _____

As part of your healthcare, this practice originates and maintains paper and/or electronic record describing your health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your care
- Submit your diagnosis and treatment information for payment from insurance companies or others

By signing this document, and "only as permitted by State or Federal law", you are giving this practice your consent to do the following:

- **To disclose, as may be necessary, your health information to other healthcare providers (such as, referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.**
- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment**
- **To submit your diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of services**
- **Leave appointment reminders or information, we believe necessary for treatment or payment, with a family member or on an answering machine. The information, will be the minimum necessary in our professional judgment**
- **Discuss your health information (only as necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments**
- **Please list by name and relationship any person with whom we may not share your health or payment information (based on professional judgment, this practice has the right to not honor your request)**

We will make available to you our **"Notice of privacy Practice"** that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have the following rights:

- The right to read the **"Patient Health Information Privacy Practices"** prior to signing this consent
- The right to request a copy of the **"Patient Health Information Privacy Practices"** for your own personal use

I hereby give my permission for the use of orthodontic records, including photographs, made in the process of examinations, treatment, and retention for purposes of professional consultations, research and education, publication in professional journals, scientific papers, demonstration or marketing purposes.

I fully understand and agree to this consent and acknowledge the above rights and disclosures.

_____	_____	_____
Signature	**Print name of person signing**	**Date**

*If other than a patient is signing, are you the parent, legal guardian, and legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [] No []
RELATIONSHIP: _____.
If you are not the parent, please provide a copy of your legal authority for this patient.

FOR OFFICE USE ONLY
[] "Consent form" reviewed by (employee) _____ on (date) _____
[] Patient refused to sign the consent form. Reason for patient refusal to sign _____
[] Restrictions added by the patient (see restrictions listed above)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

CHILD'S NAME: _____ DOB: _____

I (We) the parent (s) or legal guardian (s) authorize the individual(s) named below to act in my (our) behalf with the full authority to grant permission for any dental treatment or procedure that is in the best interest of the above named child in the opinion of the ASO providers, licensed to practice in the State of Florida. In addition, the provider is hereby authorized in an emergent situation to perform whatever acts that in his/her professional opinion are in the best interest of the above-mentioned child. I understand that the provider may request to contact the parent/guardian prior to providing dental treatment even through this consent is presented. I understand that as parent(s) or legal guardian(s) that I am financially responsible for all care received as a result of the consent.

ADULTS THAT MAY SIGN FOR DENTAL TREATMENT IN MY (OUR) ABSENCE:

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

Name: _____ Phone #: _____

Address: _____

ADULTS THAT ARE NOT AUTHORIZED TO SIGN FOR DENTAL TREATMENT:

List anyone who is not authorized to sign for treatment in the event of divorce/legal custody matters.

Name: _____ Name: _____

This consent form will be in effect for 12 months from signing or less time is specified: _____

AUTHORIZED BY: (Both parents signature preferred, but not required)
By signing below, I certify that I am the legal parent or guardian of the child identified above and am acting within my authority in signing this consent form.

Mother (Printed): _____ Witness: _____

Signature: _____ Date: _____

Father (Printed): _____ Witness: _____

Signature: _____ Date: _____

Legal Guardian (Printed): _____ Witness: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY
[] "Consent form" reviewed by (employee) _____ on (date) _____
[] Patient refused to sign the consent form. Reason for patient refusal to sign _____
[] Restrictions added by the patient (see restrictions listed on page)