

Marris Orthodontics

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient information

Name: _____

Address: _____

Home #: _____ Alternate #: _____

Section B: To the patient-Please read the following statements carefully

Purpose of Consent: By signing this form you are consenting to the release of your protected health care information as outlined in our Notice of Privacy Practices to the following people:

<input type="checkbox"/> Spouse: _____	<input type="checkbox"/> Parent: _____
<input type="checkbox"/> Sibling: _____	<input type="checkbox"/> Grandparent: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> None: _____

Right to Revoke: You have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to *HIPPA Coordinator, 12780 Waterford Lakes Pkwy, Suite 130, Orlando, FL, 32828*. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent prior to receiving your revocation.

I, _____, have had full opportunity to read and consider the contents of this Consent in conjunction with the Notice of Privacy Practice. I understand, that by signing this Consent form, I am giving my consent to your use and disclosure of necessary protected health information to carry out treatment, payment, and healthcare operations to include the above stated persons.

Signature

Relationship to Patient

Date