CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: *Patient Giving Consent*

Name: ____

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 to carry out treatment, payment activities, and healthcare operations.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Mendy Ritchie, D.D.S.
609 Highway 281 N
Marble Falls, Texas 78654
P: (830)265-6500
info@bracedorthodontics.com

Right To Revoke -
You will have the right to revoke this consent, at any time, by sending a written Notice of Revocation to the contact person listed above. Please understand that revocation of this consent will affect any action we took in reliance on this consent. Please understand that we may decline to treat you or continue treating you, if you revoke this consent.

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, payment activities, and healthcare 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: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

Signature: ____ Date: ____________________