HIPAA CONSENT FORM

Bright Orthodontics, LLC Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. We also have it posted in the reception area of our office. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the use of their information, but the Practice has the right to disclose information if they deem it absolutely necessary. For example in an emergency situation
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease

Patient's Name _____

Below is a list of ways the office could contact you. Please check your preferred method of communication and all that apply. Checking a box will give permission to leave, as thorough of a message as needed, from Bright Orthodontics.

____Patients Cell, text call both ___Patient's email

____Mother's Cell, text call both ___Father's Cell, text call both

____Mother's email ___Father's email

____Mother's work phone ___Father's work phone

____ Any of the above

____ Emergency Contact/please provide name, phone # and relationship_____

List names and relationship of who can have access to medical information. What parts of the information are they allowed access? Please included anyone who would bring the patient to appointments or is financially responsible for treatment. If you need more room, please add to the back of this form. (Please list the parent that has not signed this form.)

_____ Relationship to patient: _____ Full access Partial access

_____ Relationship to patient: _____ Full access Partial access

_____ Relationship to patient: _____ Full access Partial access

Signature of Patient or Legal Guardian _____ Date _____
(Patients 18 and over must complete this form)

Patient refuses to sign - Staff and one witness - sign below:

Staff Signature _____ Date _____

Witness Signature _____ Date _____