EDINA ORTHODONTICS ASSOCIATES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

ATTENTION PARENT/GUARDIAN- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of consent: By signing this form, the patient consents to use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: The patient has the right to read our Notice of Privacy Practices before the patient decides whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make of the patient's protected health information, and of other important matters about the patient's protected health information. We encourage the patient to read the Notice 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 issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of the patient's protected health information that we maintain.

The patient may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, directly from our office at any time. Contact in person or by the phone and we will mail or fax a copy to the patient.

Right to Revoke: The patient will have the right to revoke this Consent at any time by giving us written notice of the patient's revocation submitted to our office. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received the patient's revocation, and that we may decline to treat the patient or to continue treating the patient if the patient revokes this Consent.

Patient's Name: _____
I, _____, have had full opportunity to read and consider the contents of this Consent form, I am giving my consent to use and disclosure of the patient's 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 Name: _____
Relationship to patient: _____

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