CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient name: _____
Address: _____
Phone: _____ E-mail: _____

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of the Consent: By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, business, and healthcare operations.

Notice of Privacy Practices: You have the right to read out Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, business, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in the 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 your protected health information that we maintain.

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

ASHRAF ORTHODONTICS
141 Camino Alto #5, Mill Valley, CA 94941
Phone: (415) 388-2876
Fax: (415) 388-7982
smiles@millvalleyorthodontics.com

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Office listed above. Please understand that revocation of the Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to 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/my child's protected health information to carry out treatment, payment activities, business, and healthcare operations

Signature: _____ **Date:** _____

Name: _____

Relationship to patient: _____

PLEASE LET US KNOW IF YOU WOULD LIKE A COPY OF THIS CONSENT FORM