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.

_____ _____ _____

{Patient Name} {Signature of Patient or Parent /Guardian} {Date}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, 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 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 your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to this office. Please understand that revocation of this Consent will *not* affect any action we took in reliance on 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.

SIGNATURE OF 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 heath care operations.

Signature: _____ Date: _____ Relationship to Patient: _____

REVOCATION OF CONSENT I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____ Relationship to Patient: _____

AUTHORIZATION TO RELEASE PATIENT RECORD INFORMATION

I, _____, hereby authorize Carlton Orthodontics to disclose facial and/or dental photographs, photographs, and video for the patient listed above.

Please check the appropriate answer to each of the following questions:

1. May the patient's picture/name be displayed ***on the sign in computer screen*** for patient sign-in purposes?
   Y_____N_____
2. May the patient's picture be displayed ***on the office website, Facebook account and /or within the office*** for the purpose of informing patients of the positive outcome we have achieved?
   Y_____N_____
3. May the patient's picture be displayed ***on the office website, Facebook account and /or within the office*** if they are a contest prize winner?
4. Y_____N_____
5. May the patient's records including photographs be used for the purposes of professional consultations, research, education or publication in ***professional journals***?
   Y_____N_____

Please Note:

Financial Disclosure: I understand that the practice is not receiving compensation from anyone for use of the patient's photo.

Refusal to Sign: I understand that refusal to sign part or all of this Authorization will in no way affect the patient's treatment.

Revocation: I understand that I may revoke this authorization at any time by sending a written notice to the practice. All photos will be removed at the time the revocation is received.

Certification:

_____ I certify that I am the authorized representative for the patient. My relationship to the patient is: _____

_____ I certify that I am the patient.

Signature: _____ Witness: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS ACKNOWLEDGEMENT/CONSENT AFTER YOU SIGN IT

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

___ Individual refused to sign ___ An emergency situation prevented us from obtaining acknowledgement___ Communications barriers prohibited obtaining the acknowledgement ___ Other (Please Specify) _____