

Mashpee Orthodontics, P.C.
Consent Release Information
Privacy Notice Acknowledgement

My signature authorizes Mashpee Orthodontics, P.C. to release any medical or other information for purposes such as treatment, payment or health care operations. I authorize payment of benefits directly to Mashpee Orthodontics, P.C..

Print
Parent/Guardian/Self

Signature
Parent/ Guardian/Self

Date

Office Use Only

I attempted to obtain the patient's signature on this Confidentiality/Privacy Notice Acknowledgement, but was unable to do so as documented below.

Date _____ Initials: _____ Reason: _____

I understand that, under Health Insurance Portability & Accountability Act 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received the Mashpee Orthodontics, P.C. Confidentiality/Privacy Notice containing a more complete description of the uses and disclosures of my health information. I understand that I have the right to review Mashpee Orthodontics, P.C. Confidentiality/Privacy Policy at any time. I understand that Mashpee Orthodontics, P.C. has the right to change its Confidentiality/Privacy Policy from time to time and that I may obtain a paper copy of the updated policy from Mashpee Orthodontics, P.C. at any time.

I understand that I may request that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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