

Authorization to Disclose or Access Health Information for {PATNAME}

Your protected health information, such as names, dates, phone or fax numbers, e-mail addresses, home addresses, social security numbers, and demographic data may be used or disclosed in the following respects:

- To other health care providers such as your general dentist or an oral surgeon in connection with our rendering orthodontic treatment to you in determining the need for cleanings, surgery, or other oral needs
- To third party payers or spouses such as insurance companies, employers with direct reimbursement or administrators of flexible spending accounts, in order to obtain reimbursement of your payment (i.e., to determine benefits, dates of payment, etc.)
- To obtain certification, licensure or accreditation from bodies such as the American Board of Orthodontics or state dental boards
- To all internal staff members who have any role in your treatment
- To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.
- To your family and close friends involved in your treatment
- Contact from our office to you for providing appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information
- Request confidential communication of your protected health information
- Inspect and obtain copies of your protected health information by asking us
- Amend or modify your protected health information under certain circumstances
- Receive an accounting of certain disclosures made by within 180 days us of your protected health information
- Without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us at 1601 Cedar Lane Road, Greenville, SC 29617 or the United States Secretary of Health and Human Services

We are committed to the following duties under the privacy rules:

- To maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information
- To abide by the terms of our Privacy Notice that is currently in effect
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us and that if we do so, we will provide you with a copy of the revised Privacy Notice

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information
- Amend your protected health information if, for example, it is accurate and complete
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke. This privacy notice is effective as of the date of your signature.

Should you have any questions about the information in this notice, please contact our Treatment Coordinator.

I hereby acknowledge that I have **received/declined** and reviewed a copy of this Privacy Notice.

Signature _____ **Patient/Parent/Guardian**

Print Name _____ {ADATE}