HIPAA CONSENT FORM

ADVANCED

Advanced Orthodontics
2202 State Ave, Suite 200
Panama City, FL 32405

Patient Name_____

Patient Date of Birth_____

HIPAA- Notice of Privacy Practices

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Advanced Orthodontics may use or disclose your protected health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations. Our Notice of Privacy Practices is available for you to view on our website, www.advancedorthodontics.info, or a copy can be obtained by contacting our office. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices.

_____I certify that I have had the opportunity to review the Notice of
(initial) Privacy Practices of Advanced Orthodontics.

_____I give Advanced Orthodontics permission to discuss treatment with
(initial) anyone who brings me/my child to appointments.

Name of Responsible Party_____

Relationship to Patient_____

Signature_____

Date_____

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Patient HIPAA Electronic Communications Acknowledgment and Consent Form

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

____ I consent to and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is _____

____ I do NOT consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Date _____

Patient Name _____

Patient/Guardian Signature _____

AAO American Association of Orthodontists

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Last Name _____ **First Name** _____

Patient's Date of Birth _____

Patient's Address _____

I, _____, hereby authorize Advanced Orthodontics
(Name of Patient OR Parent/Legal Guardian if patient is under 18 years of age)
to release information, as indicated below, to the following person(s):

Name	Relationship to Patient	Phone Number	Check the Information to Release: Any	Clinical	Financial

I authorize Advanced Orthodontics to contact the individual(s) listed above to convey information as listed above regarding the 'patient' in the event that I am unable to be reached by Advanced Orthodontics.

I understand that I may revoke/cancel this authorization by notifying Advanced Orthodontics, in writing, of my intent to revoke authorization, or change the name(s) of those listed to whom the information is to be released.

_____ _____

Signature of Patient OR Parent/Legal Gaurdian if Patient is under 18 years of age

Date