HUDSON
ORTHODONTICS FOR ALL AGES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

NAME: _____

ADDRESS: _____

TELEPHONE: _____

Patients 18 years and older:
I give consent to discuss my Orthodontic **Treatment** with: (Please print)
It is the right of a parent(s) to know this information unless you have provided a court document stating otherwise.
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

GUARDIAN OR Patients 18 years and older:
I give consent to discuss my **Financial** account with: (Please print)
_____ Relationship: _____
_____ Relationship: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
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 disclosure we may make of your protected health information, and of other important matters abut your protected health information. A copy of our Notice is available upon request.

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, at any time by contacting:
Contact person: Hudson Business. Office Suite 1
Telephone: 217-429-7070 Fax: 217-429-7189
Address: 2 N. Country Club Rd. Decatur, IL 62521

__ **By Checking here, I consent to the following:** The orthodontic practice or its service provider may contact me to provide health care information such as **appointment reminders** and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.
Signature _____ Date _____
Please call the office right away if you get a new phone number!

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 health care operations:

Signature: _____ Date: _____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Relationship to Patient: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not effect any action we take in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

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 effect 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: _____