ROBBINSVILLE
ORTHODONTICS

CONSENT

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from my insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Policy Practices (for a more complete description of uses and disclosures) before signing consent.

I understand I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the respect. If the practice agrees to my requested restrictions, they must follow the restrictions.

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

If signed by patient representative, state relationship to patient.

- ❑ Self
- ❑ Mother
- ❑ Father
- ❑ Other_____

I HAVE READ AND UNDERSTAND THE ABOVE CONSENT TO TREATMENT

DATE: _____

PATIENT NAME: _____

PARENT/GUARDIAN SIGNATURE: _____