LANG ORTHODONTICS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT INFORMATION

Name:_____ **Date**_____

Address:_____ **State**_____ **Zipcode**_____

Home Telephone:_____ **Cell**_____ **e-mail**_____

SECTION B: To the patient or Personal Representative of patient - Read the following:

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 disclosures we may make of your childs/your protected health information, and of other important matters about your childs/your protected health information. A copy of our Notice is displayed in our office. You have the right to obtain a copy of our Notice of Privacy Practices 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.

Contact Officer: Martin T. Lang, D.D.S.,
1407 York Road, Suite 204,
Lutherville, MD 21093, Telephone: 410-821-6458,
Fax: 410-321-1610, e-mail: marty@langortho.com

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

Signature:_____ **Patient or Legal Guardian (please circle)**

Relationship to Patient:_____ **Date**_____

****I give my permission to Lang Orthodontics to disclose protected health information to the following family members:**

Name:_____ **Relationship**_____ **Telephone**_____

Name:_____ **Relationship**_____ **Telephone**_____