Patient Consent for Use and Disclosure of Protected Health Information

With my consent, designated Castle Pines Orthodontics' personnel may use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Healthcare Operations (TPO). Please refer to Castle Pines Orthodontics' Notice of Privacy Practices for a more complete description of such uses and disclosures.

I fully understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. Castle Pines Orthodontics reserves the right to revise its Notice of Privacy Practices at anytime.

With my consent, Castle Pines Orthodontics' personnel may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assists Castle Pines personnel in carrying out Treatment, Payment, and Healthcare Operations (TPO), such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, designated Castle Pines Orthodontics' personnel may e-mail to my home or other designated location any items that assist Castle Pines Orthodontics in carrying out TPO, such as appointment reminder cards and statements. I have the right to request that Castle Pines Orthodontics restrict how it uses or discloses my PHI to carry out TPO. However, Castle Pines Orthodontics is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Castle Pines Orthodontics' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that Castle Pine Orthodontics has already made disclosures in reliance upon my prior consent. It I do not sign this consent, Castle Pines Orthodontics may decline to provide treatment to me, forward insurance claims on my behalf, or provide protected PHI to sources outside Castle Pines Orthodontics.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____

Print Name of Patient or Legal Guardian

Patient Authorization for Practice to Release Protected Health Information to Third Parties

By signing this authorization, I authorize designated Castle Pines Orthodontics' personnel to use and/or disclose certain Protected Health Information (PHI) about me to or for the party or parties' necessary to complete **Treatment, Payment and Healthcare Operations (TPO).**

This authorization permits Castle Pines Orthodontics to use or disclose the minimum necessary **Individually Identifiable Health Information (IIHI)** to complete my TPO. This authorization includes all IIHI and PHI unless restricted, as delineated below:

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that Castle Pines Orthodontics has acted in reliance upon this authorization. My written Revocation must be forwarded to the designated Castle Pines Orthodontics HIPAA Compliance/Security Officer, at 363 Village Square Lane, Suite 155, Castle Rock, CO 80108, to become legally effective and/or binding.

Signed by: _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Patient Name | Date

_____

Print Name of Patient or Legal Guardian