BRITTON
ORTHODONTICS

Privacy Consent

Prior to any orthodontic care, we recommend reviewing this form. Any restrictions to the use of your protected health information may be requested at any time, however, depending on the nature of the request it may not be honored. We kindly ask for any restrictions to be submitted in writing so we can update the patient file accordingly. We may amend this privacy notice at any time.

Your protected health information (i.e. Individually identifiable information including, but not limited to, names, dates, phone number, email address, home address, and social security number) may be used, but is not limited to, in connection with your treatment, payment of your account, health care operations, and collaboration with applicable medical providers (ex. Your dentist, physician, etc.).

We may send information regarding patient care via mail or e-mail in order to offer the best in orthodontic care. However, there are inherent risks to transmitting information. We will not, however, transmit financial or social security number information.

Orthodontics involves consistent, regular visits to our office. At many of these visits, we typically update whoever brings the patient to the appointment. If you would not like anyone but a legal parent or guardian to get updates regarding the treatment progress, please let our office know in writing.

In the event of divorced parents and/or multi-family household, we will use this form and signature as consent to inform all applicable parties, including step-parents. In the event this is not acceptable, please let our office know in writing and adjustments will be made pursuant to state and federal HIPAA guidelines. We do not involve ourselves in custody matters regarding medical info and dissemination, so if restrictions need to be made on the patient account please let our office know. Pursuant to federal and state guidelines, information regarding custody and contact may need to be made available to our office. We do not request this information unless informed to do so.

In the event a review is left in a public forum (Google, Facebook, etc.) by signing this form you are allowing our office to respond, regardless of federal or state HIPAA guidelines.

If any restrictions need to be made, please let our office know. Thank you for your cooperation. Please let our office know if you have any questions or concerns. By signing the below, there is an acceptance and understanding of all the above.

Patient Name (Printed) _____

Parent/Guardian Name (Printed) [if patient is a minor] _____

Signature _____Date:_____