Forest Lake & North Branch
25 North Lake St, Suite 135
Forest Lake, MN 55025
651-464-1151

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form I consent to iSmile Orthodontics use and disclosure of my protected health information to carry out treatment, payment and healthcare operations

Notice of Privacy Practices: I have had the right to read the Notice of Privacy Practices before I signed this consent. That Notice provides a description of iSmile Orthodontics treatment, payment and healthcare operations, the uses and disclosures of my protected health information. We reserve the right to change our privacy practices as described in our Notices 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 not apply to any of your protected health information that we maintain. I understand I may request a copy of the Notice of Privacy Practices by contacting iSmile Orthodontics and one will be provided to me.

Insurance: I hereby authorize the release of any information relating to dental claims for benefits submitted on behalf of myself, and or/my dependents. I further agree that my signature on this document authorizes iSmile Orthodontics to submit insurance claims to my insurance carrier for dental benefits for services rendered or to be rendered, without obtaining my signature on each individual claim. By signing this document I hereby authorize payment of dental benefits, otherwise payable to me, payable directly to iSmile Orthodontics.

Right to Revoke: I have the right to revoke this consent at any time by giving iSmile Orthodontics written notice of revocation of this consent. That revocation of this consent will not affect any action iSmile Orthodontics took before the revocation was received and that we may decline to treat you or continue treating you if you revoke this Consent. I understand that I am entitled to a copy of the signed revocation of consent after it is signed. Consent does not expire after one year. This document will remain in effect until I revoke it in writing.

SIGNATURE OF RESPONSIBLE PARTY

I, _____ have had a full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am giving consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____

Patients Name

_____ _____

Patient/Legally Authorized Representative Signature **Relationship to patient**

_____

Date