LEGACY ORTHODONTICS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Address: _____

Telephone: _____Email: _____

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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 any healthcare operations. That includes communicating with you via text. You can now text us at our main office number, 972-618-5050. To protect you, our system encrypts all of our side of the patient communication. Just like phone calls and voicemails, texting may not always be 100% secure depending on the mobile service you use.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether or not 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 protected health information, and of other important matters about your health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

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.

You may obtain another copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Allison Becker Email: info@legacy-orthodontics.com Phone: 972-618-5050 Address: 6837 Coit Rd, Plano, TX 75024

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

Signature: _____ Date_____

If this consent is signed by a guardian or personal representative on behalf of the patient, please complete the following:

Guardian / Personal Representative's Name:

_____

Relationship to Patient:

_____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Right To Revoke Consent: 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 continue treating you if you revoke this consent.

Refusal of Consent: I refuse my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. Refusing to sign the acknowledgment does not prevent this office from using or disclosing

health information as the rule permits it to do.

I also understand that you may decline to treat or continue to treat me after I refuse my consent.

Signature: _____ Date: _____