Grayslake Orthodontics
Dr. David Hertzberg
160 Commerce Drive, Suite 101
Grayslake, IL 60030
847.548.4330
www.GrayslakeOrtho.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name_____

Patient's Birthdate_____

Responsible Party Name_____

Resp Party Social Security Number_____

Address_____

Telephone_____

Email_____

TO THE PATIENT/PARENT—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 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 protected health information, and of other important matters about your protected 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 a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jennifer Pucevich %Grayslake Orthodontics
Telephone: (847) 548-4330 Fax: (847) 548-4335
Address: 160 Commerce Drive, Suite 101 Grayslake, IL 60030
Email: info@grayslakeortho.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 to continue treating you if you revoke this Consent.

Signature: I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I am entitled to a copy of this consent after I sign it and will request it if desired.

_____	_____	_____
Responsible Party Signature	Relationship to Patient	Date

Revocation of Consent - Don't sign this part if you signed above.
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. **I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.**

_____	_____	_____
Responsible Party Signature	Relationship to Patient	Date