Consent Form for the
Use and Disclosure of Protected Health Information

Patient name: **Date of Birth:** **Responsible-Party name:** **Date of Birth:**

_____ _____ _____ _____

Tenley Orthodontics, Dr. Sheila Esfandiari " Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you/your children. Please acknowledge access to this office Notice of Privacy Practices by initialing here: _____

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, the notice will be posted in our office.

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Insurance carrier benefits be made on my/ my children's behalf to Tenley Orthodontics, Dr. Sheila Esfandiari for any services furnished to me by that physician. I authorize any holder of medical information about me to release to any Insurance Carriers for which I/ my children have coverage, any information needed to determine these benefits or the benefits payable for related services. I understand that all co-pays must be paid at the time of service in accordance with contracted Insurance Carrier agreements.

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Parent or Guardian Signature **Today's Date:**
(□ Signature of patient if 18 years of age or Older)

I give permission for the office of Tenley Orthodontics, Dr. Sheila Esfandiari to:

1) **Send appointment reminder postcards and/ or leave appointment reminder messages at addresses and phone numbers I have provided.**
2) **Send/ fax /phone patient information at my request, such as school health forms and authorization to dispense medication at school, even if confidentiality of this communication cannot be guaranteed.**
3) **Send/ fax health forms, prescriptions, referrals, and/ or other materials pertaining to my/ my children's care and/or status at my request to addresses I have provided.**

_____

Parent or Guardian Signature **Today's Date:**
(□ Signature of patient if 18 years of age or Older)

Please return this complete form to the receptionist.