ORTEGA
ORTHODONTICS

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CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Ortega Orthodontics, PLLC to use and disclose the entire medical record concerning _____, in accordance with the Notice of Privacy Practices (NOPP). I have reviewed the NOP, been given an opportunity to ask questions about it, understand it, and do hereby agree to its terms. A copy of this signed, dated, Consent shall be as effective as the original. I release, hold harmless, and agree to indemnify Ortega Orthodontics, its employees and agents for any and all liability (including, but not limited to negligence) arising out of or occurring under this Consent. I specifically authorize Ortega Orthodontics to use and disclose verbally, by mail, fax, or e-mail, any confidential medical information that Ortega Orthodontics deems pertinent to treatment.

COMPLETE THIS SECTION FOR TRANSFER OF RECORDS (AS APPLICABLE):

1. Please send a copy of my records (including all information it may contain from other health care providers) to _____ at _____. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.
2. Please allow _____ to pick up a copy of my records (including all information it may contain from other health care providers). Please prepare the copies by _____(date).
3. I acknowledge I will be charged copying cost in the amount of $_____.

SIGNATURES:

Patient's Name (Print): _____

Patient Signature: _____ Date: _____

Patient's Representative: _____ Authority: _____

Representative's Signature: _____ Date: _____

As Privacy Officer, I attempted to obtain the patient's or representative's signature on this consent but I did not because _____.

Signature of Privacy Officer: _____