Reading Orthodontics, PC
2 Haven Street Suite 202
Reading, MA 01867
(781) 944-7970

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

____
(PATIENT NAME)

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 for the patient named on 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 document. 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, at any time by contacting our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took before we received your written notice. We may decline to treat or continue treating you if revoke this Consent.

I have had full opportunity to read and consider the contents of this **Consent Form** and **Notice of Privacy Practices**. I understand that, by signing this 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 for the patient named on this form.

______________________________________ ______________________________

SIGNED (PATIENT OR PARENT IF MINOR) DATE

You are entitled to a copy of this Consent form after you sign it