Fax 215-643-9702

SALLY A. GUPTON, D.D.S.

ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS FOR CHILDREN AND ADULTS

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Name: _____

Address: _____

Telephone: _____ Email: _____

Patient Chart Number: _____ Social Security Number: _____

Section B: 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 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. 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, a revised Notice of Privacy Practices will be available upon request. 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:

HIPAA Information Department
Sally A. Gupton, DDS
467 Pennsylvania Avenue, Suite 201
Fort Washington, PA 19034
Telephone: 215-643-9640 Fax: 215-643-9702

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 **Sally A. Gupton, DDS.** 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 if you revoke this Consent. I understand that revocation of this Consent cannot be used to delay or refuse payment for any services rendered by us previously.

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.

Signature: _____ Date: _____

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

Personal Representative's Name: _____

Relationship to Patient: _____

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

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