## SALLY A. GUPTON, D.D.S. ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS FOR CHILDREN AND ADULTS

## CONSENT FOR DISCLOSURE

	OF HEALTH INF	ORMATION	w.(	
Section A: Patient Giving Consent	ation de la comitation de transcription de la final de			
Name:				
Address:				
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Telephone:	Emc	:		<del></del>
Patient Chart Number:	Social Security N	umber:	<del>44 - 4 - 14 - 14 - 14 - 14 - 14 - 14 - </del>	
Section B: To the Patient – Please read t	ne following statements c	arefully		
Purpose of Consent: By signing this form carry out treatment, payment activities,			your protected hed	alth information to
Notice of Privacy Practices: You have the this Consent. Our Notice provides a desuge and disclosures we may make of your encourage you to read it carefully on the contract of the encourage you to read it carefully on the encourage you are the encourage.	scription of our treatment our protected health info	, payment activities, or rmation. A copy of or	and healthcare op	erations, of the
We reserve the right to change our prive privacy practices, a revised Notice of Pr your protected health information that y	rivacy Practices will be av	ed in our Notice of Priv vailable upon request	acy Practices. If v Those changes m	ve change our nay apply to any of
ou may obtain a copy of our Notice of	Privacy Practices, includ HIPAA Information Sally A. Gupto 467 Pennsylvania Avo	Department on, DDS	ur Notice, at any tir	ne by contacting:
	Fort Washington	, PA 19034		+
Te	elephone: 215-643-9640	Fax: 215-643-9702		2.
Right to Revoke: You will have the right of ubmitted to Sally A. Gupton, DDS, ook in reliance on this Consent before whis Consent. I understand that revocation of the consent by us previously.	Please understand that we received your revocat	t revocation of this Co tion, and that we may	onsent will not affect decline to treat yo	ct any action we ou if you revoke
IGNATURE	D	9 6 5 8 8		4 1
, t. and your Notice of Privacy Practices. I u and disclosure of my protected health in	nave had full opportunity understand that, by signin nformation to carry out tre	a this Consent form, I	am giving my cons	ent to your use
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this consent is signed by a personal rep				
ersonal Representative's Name:		and the second s		*
elationship to Patient:	entitled to a copy of this			8
You are	entitled to a copy of this	Consent after you sig	jn ir.	

SALLY A. GUPTON, D.D.S.
ORTHODONTICS AND DENTOFACIAL ORTHOPEDICS FOR CHILDREN AND ADULTS

	OF HEALTH INFORMAT		
Section A: Patient Giving Consent			
Name:			
Address:			<del></del>
Telephone:	Email:		April Marches Superal San Law.
Patient Chart Number:	Social Security Number	in the second	
Tallotti Gran Northbolt.			
Section B: To the Patient — Please read the foll	lowing statements carefully		
Purpose of Consent: By signing this form, you carry out treatment, payment activities, and		lisclosure of your protecte	d health information to
Notice of Privacy Practices: You have the rig this Consent. Our Notice provides a descripti uses and disclosures we may make of your pr We encourage you to read it carefully and c	ion of our treatment, paymer rotected health information.	nt activities, and healthca A copy of our Notice acc	re operations, of the
We reserve the right to change our privacy p privacy practices, a revised Notice of Privacy your protected health information that we me	Practices will be available u	Notice of Privacy Practice pon request. Those chan	s. If we change our ges may apply to any of
You may obtain a copy of our Notice of Priva	HIPAA Information Departm	evisions of our Notice, at a	any time by contacting:
4	Sally A. Gupton, DDS 67 Pennsylvania Avenue, Sull	le 201	
	Fort Washington, PA 1903	4	a .
Telepho	one: 215-643-9640 Fax: 21	5-643-9702	t.
Right to Revoke: You will have the right to reversibilitied to Sally A. Gupton, DDS. Pleatook in reliance on this Consent before we realthis Consent. I understand that revocation of rendered by us previously.	ase understand that revocation and	ion of this Consent will not that we may decline to tr	t affect any action we eat you if you revoke
SIGNATURE	9		4
,, have to and your Notice of Privacy Practices. I unders and disclosure of my protected health information	had full opportunity to read o stand that, by signing this Cor ation to carry out treatment,	nsent form, I am giving my	consent to your use
signature:	Date:		
f this consent is signed by a personal represer	10 to	· ·	
Personal Representative's Name:			olis ota sainta sai
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Relationship to Patient: You are entit	led to a copy of this Consent	after you sign It.	