HIPPA Patient Consent Form

AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

This form is used to obtain authorization to release Protected Health Information regarding the following patient(s):

Patient Name: _____

Patient Name: _____

Patient Name: _____

I understand that I, or my child, have/ has certain rights to privacy regarding my/ his/ her protected health information. These rights are given to me/ him/ her under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize A List Smiles Orthodontics, Alyssa Sprowl, DDS, MS, PLLC and its employees (collectively known as "A List Smiles Orthodontics") to use and disclose my protected health information to carry out:

1. Treatment (including treatment by other healthcare providers involved in my treatment).
2. Payment collection from third party payers (i.e. insurance companies).
3. The day to day healthcare operations of the practice.
4. Educational and demonstrational activities.

I understand that A List Smiles Orthodontics reserves the right to change the terms of this notice from time to time and that I may contact A List Smiles Orthodontics at any time to obtain a more current copy of this notice. I understand that I have the right to request restrictions on how my or my child's protected health information is used and disclosed to carry out treatment, payment, health care operations, and educational and demonstrational activities.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I authorize* A List Smiles Orthodontics *to disclose my/ my child's Protected Health Information to the following people:

_____

Responsible Party Name (Print)

_____

Responsible Party Signature

_____

Date

A List Smiles Orthodontics
Dr. Alyssa Sprowl
2510 Vista Drive
Suite 103
Charlotte NC 28212
(704)665-7078
www.myalistsmiles.com