SOUTH HILLS ORTHODONTICS
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LIMITED CONSENT TO RELEASE OR USE HEALTH INFORMTAION

PATIENT GIVING CONSENT:

Name _____

Address _____

Primary Phone _____

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT 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.

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 Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature _____

Date _____

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

Name _____

Relationship to Patient _____