CREEKSIDE ORTHODONTICS

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Other Healthcare Operations

You May Refuse To Sign This Acknowledgment

We are disclosing this policy as required by Federal and Montana state regulations.

I understand that as part of my healthcare, this Practice originates and maintains Health records describing my health history, symptoms, examination and test results, procedures and diagnoses, and treatment plans for the future care.

I have been provided with a copy of this office's Notice of Privacy Practices. I understand that I have the right to review the notice prior to signing this consent. I also understand that Creekside Orthodontics reserves the right to change their notice and practices and I will be notified of these changes. I understand that I have the right to place additional restrictions on the use or disclosure of my health information. I also understand that Creekside Orthodontics is not required to agree to the restrictions requested.

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Signature of Patient or Guardian Date

CREEKSIDE
ORTHODONTICS