Patient HIPAA Awareness

With my permission, Glaser Orthodontics may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Glaser Orthodontics Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Glaser Orthodontics reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Glaser Orthodontics may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Glaser Orthodontics may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my permission, the office of Glaser Orthodontics may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Glaser Orthodontics restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Glaser Orthodontics to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian

_____ _____

Print Name of Patient or Legal Guardian Date

SEE OTHER SIDE

SUPPLEMENTAL CONSENT/ACKNOWLEDGMENT FORM

By signing below and checking "yes", you consent to allow Barry J. Glaser DMD, PC, to do the following:

	YES	NO
1) Display your first name and photograph in our office.	☐	☐
2) Display your first name and photograph on our website.	☐	☐
3) Use your orthodontic records for educational purposes.	☐	☐
4) Have your signature on file for insurance purposes.	☐	☐

PATIENT'S NAME _____DATE_____

SIGNATURE_____