



James J. Tomassetti, DMD
Diplomate, American Board of Orthodontics

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Patient name: _____ Date of visit: _____

My signature on this form acknowledges that I've received a copy of Apple Creek Orthodontics, Ltd.'s Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Apple Creek Orthodontics, Ltd., and of my rights with respect to my health information.

By signing this form, I consent to Apple Creek Orthodontics, Ltd.'s use of my patient health information to carry out treatment, payment activities, and health care operations as set forth in their Notice of Privacy Practices.

I've been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient's signature Date

Person Completing Form _____ Email: _____

Signature of patient's representative Date
(use when patient is a minor or unable to sign)

I hereby give consent to Apple Creek Orthodontics, Ltd. to give my patient information to:

Print name and relationship to patient Date

Print name and relationship to patient Date

Print name and relationship to patient Date

This consent is effective until revoked by me. I may revoke this consent at any time by giving written notice of revocation to Apple Creek Orthodontics, Ltd. Revocation of this consent will not affect any action Apple Creek Orthodontics, Ltd took in reliance on this authorization before receiving written notice of revocation. Treatment may be declined or discontinued if consent is revoked.

Section below to be completed by Apple Creek Orthodontics, Ltd. if form is not signed:

1. Was the patient/representative provided with a copy of the Notice of Privacy Practices? YES NO

2. Briefly describe the efforts made to obtain the patient/representative's acknowledgement of receipt of the Notice and explain why the patient/representative was not able or willing to sign this form:

