Consent for Use and Disclosure of Personal Health Information
And Permission to Release Financial Information

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides the uses and disclosures of my personal health information, my rights, how I may exercise these rights, and the practice's legal duties with respect to my information. This form authorizes our office to use and disclose your protected health information (PHI) for the purposes of orthodontic treatment and release financial information to the individuals indicated below.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice.

For questions concerning our Notice of Privacy Practices, please contact the office:

Dr. Ashlee Weber (816) 746-1200

Patient/Parental Consent:

Patient Name:____

Patient Date Of Birth:____

Address:____

City:_______________________State:_________________Zip:________

Telephone:____

Patient Account #:____

Parent Information:

I, ______________________________, have read your Notice of Privacy Practices and I consent to your use of my PHI for the purposes of orthodontic treatment, and release of financial information to the individuals indicated below.

Printed Name:____

Signature:___________________________________Date:_______________

Social Security # or Driver's License #:_________________________________

Release Financial Information (fee amount, payment arrangements, receipts, money due, and/or balances) to the following individual(s) for the above named patient:

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