Patient Consent for Use and Disclosure
Of Protected Health Information

I authorize my doctor to release my medical records, including, but not limited to, radiographs (xrays), reports, charts, medical history, photographs, findings, plaster models or impressions of teeth, prescriptions, diagnosis, medical testing, test results, billing, and other treatment records in my doctors possession ("Medical Records") (i) to other licensed dentists or orthodontists and organizations employing licensed dentists and orthodontists for the purpose of investigating and reviewing my medical history as it pertains to orthodontic treatment for educational and research purposes.

I understand that use of my Medical Records may result in disclosure of my "individual identifiable health information" as defined by the Health Insurance Portability and Accountability Act (HIPAA). I hereby consent to the disclosure as set forth above. I will not, nor shall anyone on my behalf seek legal, equitable or monetary damages or remedies for such disclosure. I acknowledge that use of my Medical Records is without compensation and that I will not, nor shall anyone on my behalf have any right of approval, claim of compensation, or seek or obtain legal, equitable or monetary damages or remedies arising out of any use such that comply with the terms of this Consent.

A photostatic copy of this Consent shall be considered as effective and valid as an original. I have read, understand and agree to the terms set forth in this Consent as indicated by my signature below.

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Print Patient Name

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Signature of Patient or Parent **Date:______________**