NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices of Yamashiro Orthodontics. I hereby authorize, as indicated by my signature below, Yamashiro Orthodontics to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

I have also been informed of and given the right to review and secure a copy of your notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected heath information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number:_____
  leave Message? Y N
- ☐ You may contact me on my cell phone number: _____
  leave Message? Y N
- ☐ You may contact me on my work telephone number: _____
  leave Message? Y N
- ☐ You may send me an unencrypted email/text message at: _____
- ☐ Other: _____

Please list authorized persons with whom we may discuss your protected health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed:_____
2. _____ Date Added/Removed:_____
3. _____ Date Added/Removed:_____
4. _____ Date Added/Removed:_____
5. _____ Date Added/Removed:_____

PHOTO RELEASE FORM

I hereby authorize Yamashiro Orthodontics or any of their assignees to take photographs, xrays, and/or videos of my or my child's teeth, jaws, and face. I understand that the photographs, xrays, and videos will be used as a record of my care and progress, and may be used for communication with other health care professionals, and/or publications. The content may also be used for advertising purposes (including website publication, Facebook and/or Instagram posts, etc). I further understand that if the photographs, xrays, and/or videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing at any time.

Please initial one option:

_____I do not mind if my/my child's photographs are used in any of the above stated situations.

_____I do not mind if my/my child's photographs are used for internal purposes only (i.e, debond wall).

_____I ONLY agree to have my/my child's teeth shown without any identifying features (i.e, name or face).

_____I DO NOT authorize the use of my/my child's photos for any of the above stated situations.

Signed_____ Date_____