

JOHN F. MONACELL, D.D.S., P.C.

PRIVACY CONSENT

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health and Human Services. We have elected to use this form. Prior to commencing your orthodontic treatment, you should review, sign and date this form.

Your protected health information (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used in connection with your treatment, payment of your account or health care operations (i.e., performance reviews, certification, accreditation, and licensure).

You have the right to review our office's privacy notice prior to signing this Consent.

You have the right to request restrictions on the use of your protected health information. However, we are not required to honor your request.

We may amend the attached privacy notice at any time. If we do, we will provide you with a copy of the changes, and the changes may be implemented prior to the effective date of the revised notice.

You may revoke this Consent at any time in writing. However, such revocation will not be effective to the extent that any action has been taken in reliance on this Consent.

Thank you for your cooperation. Please let us know if you have any questions.

Patient Signature

Print Name

Date

Parent/Guardian Signature (If Applicable)

Print Name of Parent/Guardian (If Applicable)

Date

JOHN F. MONACELL, D.D.S., P.C.

PRIVACY AUTHORIZATION

This authorization is required by the privacy regulations recently promulgated by the United States Department of Health and Human Services.

Your protected health information, including individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, demographic data, photographs, x-rays, study models, medical/dental histories and other diagnostic and treatment information will be used or disclosed for the following purposes:

- Research
- Lectures/presentations
- Publications
- Practice Marketing

The following people will disclose this information: Dr Monacell, his employees and others working on behalf of Dr Monacell.

The information will be disclosed to the following people/entities: medical and dental practitioners, health care workers, potential patients and others desiring information about orthodontic and dental treatment.

This authorization will expire on December 31, 2025.

You have the right to revoke this Authorization at any time in writing. However, your revocation will not be effective to the extent that this Authorization has been relied on. If your treatment will be used for research purposes, we may condition your treatment on obtaining this Authorization, in which case you may not receive treatment.

The information used or disclosed per this Authorization may be subject to re-disclosure by the recipient(s) and thus, no longer protected by the privacy rules.

Patient Signature

Print Name

Date

Parent/Guardian Signature (If Applicable)

Print Name of Parent/Guardian (If Applicable)

Date