Dr. Hoda Salim DDS, MS

Phoenix Location:
16620 N. 40th St, Suite A-1
Phoenix, Arizona 85032

Glendale Location:
6120 W Bell Rd #190
Glendale, Arizona 85308

(602)485-4700 ssorthodonticsphx.com

CONSENT FOR USE AND DISLOSURE OF HEALTH INFORMATION

Name: _____ Phone Number: _____

Address: _____

Email Address: _____

TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operation, of the uses and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the change. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contract Person: Paula Thomasson
Telephone: (602) 485-4700 Fax: (602) 485-4720
Email: ssorthodontics@toothemail.com
Address: 16620 N. 40th Street, Suite A-1, Phoenix, Arizona 85032

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance of this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____, have had full opportunity to read and consider the contents of this Consent from and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____