To My Patients,

So that we may provide you with the best possible state of the art orthodontic services available, I feel it is necessary to take photographs and study models. I would appreciate you taking the time to read and sign this consent form.

Thank –you
Dr. John B. Harrison

Please Read This Form Before Signing:

Name: _____ Date: _____

I hereby give permission to Dr. John B. Harrison, or any staff he may designate, to take photographs and study models for diagnostic purposes and to enhance the dental records. I agree that these photographs will remain the property of Dr. John B. Harrison. I further authorize him to use such photographs for teaching purposes or to illustrate scientific papers, books, or lectures, if in his judgement dental research, education or science will be benefited by their use. Patient photographs may also be used for illustration purposed when previewing types of esthetic dental treatment with other patients. It is specifically understood that in any such publications or use I shall not be identified by name.

Date: _____ Signature: _____

(Patient or person authorized to give consent
Of the patient)

Patient Consent to Use and Disclosure Information for Treatment, Payment Health care Operations

I, _____understand that as part of my health care we,
John B. Harrison, D.D.S.,M,Sc originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the dental professionals who contribute to my care, such as referrals.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means which a third- party can verify that services billed were actually provided.
- A tool or routine health operations, such as assessing quality and reviewing the competence of staff

I have been provided with a Notice of Patient Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to view *Notice* prior to signing this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I further understand that John B. Harrison, D. D. S., M, Sc. reserves the right to change his notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. Should John B. Harrison, D.D.S., MSc. Change his notice , I may request a copy of any revised notice in person (or by U.S. mail, to be sent to the address I've provided).

I wish to have the following restrictions to the use or disclosure of my health information:

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operations:
Example: Spouse (names), children (names), other relatives (names), friends or caregivers (names)

Appointment Reminders:
May we leave an appointment reminder message at your home using doctor's/practice name: Yes [ ] No [ ]
May we leave an appointment reminder message at your work using doctor's/practice name: Yes[ ] No [ ]

I understand that as part of treatment, payment, or healthcare operation, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and accept/decline the terms of this consent.

*If other than patient is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or other healthcare operations Yes [ ] No [ ]

Patient/Guardian Signature Print name of person signing

Date

FOR OFFICE USE ONLY
[ ] Consent received by _____ Date:_
[ ] Consent refused by patient [ ] Restrictions
[ ] Consent added to patient's record on_____