



**AMLEY & AMLEY D.D.S., P.A.**

**ACKNOWLEDGEMENT OF POSTED NOTICE OF PRIVACY PRACTICES**

**\*You may refuse to sign this acknowledgement\***

I, \_\_\_\_\_, have been offered a copy of the Privacy Practice Notice posted in the office of Amley & Amley D.D.S.

Please sign: \_\_\_\_\_ Date: \_\_\_\_\_

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**AUTHORIZATION TO RELEASE HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize Amley & Amley D.D.S. located in Pinellas County, FL to display the photograph of the following patient inside the office on the photo board and our check-in computer screen.

Patient/Parent signature: \_\_\_\_\_

(Revocation) I understand I may revoke this authorization at any time by sending a written notice to the practice.

(Refusal to Sign) I understand that I may refuse to sign this Authorization.

Refusal signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Purpose of this section is to inform you we need to use and disclose your protected health information to carry out treatment, payment activities, and healthcare operations. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: 727-381-1062 or [frstavfl@orthodon.com](mailto:frstavfl@orthodon.com). I understand that, by signing this Consent, 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.

Parent/Patient/Guardian \_\_\_\_\_ Date: \_\_\_\_\_