CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION REED ORTHODONTICS PLLC

I hereby authorize Reed Orthodontics PLLC, (hereafter collectively referred to as "Practice") to use and disclose the entire medical record concerning _____, file # _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have had an opportunity to review the Notice (document# 4-03), been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify the Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

I specifically authorize the Practice to use and disclose verbally, by mail, fax or unencrypted e-mail, the following types of super-confidential information as stated in the NOPP (initial where appropriate):

___ HIV records (including HIV test results) and sexually transmissible diseases

___ Alcohol and substance abuse diagnosis and treatment records

___ Psychotherapy records

COMPLETE AS APPLICABLE:.

1. Please send a copy of my records (including information from other health-care providers that it may contain) to _____ at _____. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.

2. Please allow _____ to pick up a copy of my records (including information from other healthcare providers that it may contain). The copies are requested to be ready on_____.

3. I acknowledge I will be charged actual copying costs in the amount of $_____.

I authorize the Practice to disclose medical information to the following relatives, friends or caregivers and to communicate with other health care providers regarding the above individuals orthodontic care or exam findings.

_____,_____,_____

_____,_____,_____

Date: _____

Signature of Patient or Representative: _____

Print Name: _____

Relationship to Patient: Self Mother Father Grandparent Guardian

If Guardian what is your relationship to Patient: _____