ROBERT J. ISAACSON, D.D.S.
Spec. Per. # 2018
RICHARD D. ISAACSON, D.M.D.
Spec. Per. # 3453
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Spec. Per. # 3500

ISAACSON ORTHODONTICS

ORTHODONTICS and DENTOFACIAL ORTHOPEDICS
CHILDREN and ADULTS

HIPAA

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment.

I understand and have access to the Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Your signature gives us permission to post a picture of the patient during or post treatment to our office Social Media or to use for lecture/educational purposes.

Name of Patient _____

Signature of Self/Guardian _____

Date _____