BUTTERFLY
ORTHODONTICS

PRIVACY PRACTICES ACKNOWLEDGEMENT

Privacy Notice Amendment September 2013

I have had the opportunity to read the Patient Privacy Notice for this practice. I understand that I may ask for a copy to take with me at any time, and that an appointed person is available to answer any questions that I may have now, or in the future, regarding the use on my Personal Health Information.

_____ _____

Responsible Party Signature Date

_____ _____

Practice Witness Date

Butterfly Orthodontics
4025 W. Bell Road #5
Phoenix, AZ 85053

Phone (602) 938-6709
Fax (602) 439-8485
www.ButterflyBraces.com

BUTTERFLY
ORTHODONTICS

Re: _____

Patient First Name Last Name

Dear Patient/Parent,

This is to inform you that our emails are sent through an unsecure server. What this means to you is there is a slight risk that an unauthorized person could view your personal health information. For expediency email transmissions may be the preferred method of delivery. Under our Privacy Policy patients may choose to opt out of email transmissions.

Please indicate below your preference:

☐ The orthodontic office of Dr. Chad Foster may send the minimum necessary personal health information via email. This may include letters, panoramic x-rays, photographs, I-CAT images and other personal health information needed, to accommodate your other doctors, your healthcare provider, or other entities involved in your health care.

☐ I prefer emails not be sent with personal health information.* *Note: If the second box is checked we will send all records by U.S. mail which may delay treatment.*

_____ _____ _____

Responsibility Party First & Last Name Signature Date

_____

Relationship to Patient

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CONSENT TO RELEASE PATIENT INFORMATION

Date _____

I _____ give consent for Dr. Chad Foster

First Name **Last Name**

to release any and all appointment, financial and treatment information regarding:

_____ to the following people:

First Name **Last Name**

_____ _____

First Name **Last Name** **Relationship to Patient**

_____ _____

First Name **Last Name** **Relationship to Patient**

_____ _____

First Name **Last Name** **Relationship to Patient**

_____ _____ _____

Responsible Party Signature **Printed Name** **Date**

_____ _____

Practice Witness **Date**

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Informed Refusal Radiologist Reading of CBCTs

Today, and possibly at multiple times during my orthodontic treatment, a CBCT Scan (specialized x-ray) will be taken. I _____ acknowledge that Dr. Foster has strongly advised me that I should allow Dr. Foster to share my (or my child's) CBCT Scan Data with a radiologist, at no cost to the patient, to properly review, interpret, and analyze the CBCT Scan Data. I decline and refuse that advice. I understand that my decision to not allow Dr. Foster to share that information with a radiologist may result in a failure to diagnose or evaluate a serious medical or dental condition that may result in permanent injury or death. I acknowledge those risks and decline having any and all CBCT Scan Data obtained during orthodontic treatment, including today's, shared with or reviewed by a radiologist, despite Dr. Foster's advice that they be allowed to share that Data so that it can be properly reviewed.

Patient Name: _____ DOB: _____

Patient/Parent Signature: _____ Date: _____

Witness name: _____

Signature: _____ Date: _____

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