LEBLANC ORTHODONTICS
LESTER A. LEBLANC, D.D.S., P.C.

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CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF CONSENT: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payments, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. The changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting Dr. Lester A. LeBlanc

RIGHT TO REVOKE: You have the right to revoke this Consent at any time by giving us written notice of your revocation, addressed to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving Dr. LeBlanc and staff, consent to use and disclose of my protected health information to carry out treatment, payments activities and healthcare operations.

_____ _____
Signature **Date**

CONSENT FOR INTERNET COMMUNICATIONS

I grant permission to the dental practice LeBlanc Orthodontics to upload and store confidential patient information including account information, appointment information as well as clinical information to the secured website for the dental practice. I understand that for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages or losses that may be incurred as a result of my failure to maintain confidentiality. I understand that the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the term of this agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws.

I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR ANY OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OF THE SERVICES.

☐ I have read the information above regarding the secured uploading of patient information on the website for the dental practice, and grant the dental practice permission to securely upload my patient information to the website.

_____ _____
Signature **Date**

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT