GARCIA
Orthodontics

HIPAA CONSENT

Patient First and Last Name: _____

HIPAA is a federal law developed to provide a standard for the protection of your health information. The purpose of the Notice of Privacy Practices is to explain how Garcia Orthodontics may use or disclose your health care information.

The notice also explains the rights that you are guaranteed under HIPAA regulations. Though Garcia Orthodontics has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgement that you have received the notice. Our Notice of Privacy Practices can be obtained by contacting our office. Signing below indicates that you have had the opportunity to review the Notice of Privacy Practices. I certify that I have had the opportunity to review the Notice of Privacy Practices of Garcia Orthodontics.

MEDIA AND DOCUMENTATION CONSENT

During your orthodontic consultation and treatment, pictures and x-rays will be taken. These may be used for documenting and presenting clinical cases and or for use on our digital, print or media channels. I, the undersigned, do hereby consent to the use by Garcia Orthodontics of images, voice, or both, any video, photograph, or audio/video files reproduced either in whole or in part from the video, photograph or audio files for advertising, on digital, print or broadcast, or any other purpose on behalf of Garcia Orthodontics. I waive claims to compensation or damages based on the use of my image or voice, or both, by Garcia Orthodontics. I also waive to inspect or approve the finished photograph or video or audio.

I agree that all such portraits, pictures, photographs, video and audio recordings and any reproductions thereof, and all plates, negatives, recording tape, and digital files shall remain the property of Garcia Orthodontics, unless otherwise noted. I understand that this consent is not perpetual, that I may revoke it in writing and that it is binding on my heirs and assigns.

I warrant that I am at least 18 years of age and/or represent as a legal guardian of the below mentioned individual and that I am competent in my own name insofar as this consent is concerned. I further attest that I have read this consent form and fully understand its contents.

_____
Relationship to Patient

_____
Name of Responsible Party

_____ _____
Signature Date

Member American Association of Orthodontists

FRANCISCO J GARCIA, DMD
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