JEFFREY A. HOUSLEY, DDS, MS BRENT S. DOBSON, DDS, MS

YOUR SMILE IS OUR SPECIALTY

BOARD CERTIFIED ORTHODONTISTS

PATIENT REQUEST FOR SPECIFIC DISCLOSURE OF PROTECTED HEALTH INFORMATION & CONSENT FOR CELL PHONE CONTACT

I, the undersigned, hereby request that Owasso Orthodontics communicate about all Protected Health Information (PHI) by conventional, unencrypted email. This PHI includes, but is not limited to: potential treatment plans, fees associated with treatment, insurance information, birthday well wishes, appointment dates/times and treatment progress.

I understand that this increases the risk that the PHI could be read or accessed by a third party while in transit. If my PHI is disclosed to someone who is not required to comply with the federal HIPAA regulations, then such information may be re-disclosed by the recipient and may no longer be protected by HIPAA.

I understand that I may revoke this request at any time by delivering a revocation in writing to Owasso Orthodontics. After that point, email communication with me about all PHI will be protected by password encryption. If I revoke this request, it will have no effect on actions already taken by Owasso Orthodontics in reliance on this request.

I authorize the request described herein. I have read and understand this request. I am the patient listed on this request or am authorized to act on behalf of the patient as the patient's personal representative.

☐ I consent to Owasso Orthodontics using my cell phone number to call and/ or text regarding appointments, insurance, and my account. I understand that I can withdrawal my consent at any time.

My cell phone number is: _____

Printed Name of Patient: _____

Printed Name of Legal Guardian: _____

Signature of Patient or Legal Guardian: _____

Date: _____

Witness:_____

E-mail:_____

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