Lafayette Family Orthodontics
BRIAN C. LEYPOLDT, DDS, MSD
Your Smile Is Our Specialty

Lafayette Family Orthodontics wants to assure you that your Protected Health Information (PHI) is secure with us. The Health Insurance Portability & Accountability Act is a federal program that requires all patient records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept confidential. Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends, and or other relatives regarding your treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name.

I understand that authorizing the disclosure of my health information is voluntary. Furthermore, I understand I have the right to revoke this communication authorization at any time. Revocation of the authorization must be done in writing and presented to Lafayette Family Orthodontics. Unless otherwise revoked, this authorization is valid for 1 year from date of signing.

Patient Name: _____ Patient Date of Birth: _____/_____/_____

If Patient is a Minor, Name of Parent or Legal Guardian: _____

Relationship to Patient: _____

_____ _____/_____/_____
Signature of Patient or Legal Guardian Today's Date

Confidential Communication Authorization. The Health Insurance Portability Accountability Act (HIPAA) gives you the right to request the method and location for which we communicate confidential information to you. In order to protect the privacy and confidentiality of your information, please complete the following to indicate your preferences for contact and disclosure of confidential information.

1.)Patient Contact Information *(if the patient is a minor, please write the parent/guardian name next to the phone number)*

Patient **Cell** Phone: _____May we leave detailed message? Yes No

Patient **Home** Phone: _____May we leave detailed message? Yes No

Patient **Email**: _____@_____.com May we leave detailed message? Yes No

Please circle the preferred contact number: **Cell, Email and Home**

2.)Detailed information may be disclosed to the following individual(s):

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

3.)Please list an emergency contact: Name: _____

Relationship: _____ Phone Number: _____