

# MOORE ORTHODONTICS

8300 Precinct Line Road, Suite 100

Colleyville, Texas 76034

(817) 282-0200

## PRIVACY POLICIES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care options. We are not required to agree to this restriction, but if we do we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior acknowledgment. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## SIGNATURE ACKNOWLEDGMENTS

I acknowledge that I have read the above authorization and have had the opportunity to review the Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

I, hereby authorize the release of any medical/dental information necessary for the processing of insurance. I, hereby assign all dental benefits to Moore Orthodontics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I, hereby authorize Terry L. Moore D.D.S., P.A. or Jose G. Chow, D.D.S. and staff to render care during office visits.

**I have read and understand the policies of the practice, and agree to be bound by the terms. I understand and agree that such terms may be amended in the future.**

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Patient Name

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Responsible Party (*if other than patient*) **PLEASE PRINT**

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Signature of Responsible Party (*if other than patient*)

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Date