TOMBLYN FAMILY ORTHODONTICS
CENTRAL AUSTIN | WESTLAKE | STEINER RANCH

Authorization for Use and Disclosure of Protected Health Information

_____ ***(please initial)*** I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the dental needs of the below-named patient. Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

_____ ***(please initial)*** I give Tomblyn Family Orthodontics, its employees, and/or other agents express prior consent to contact me at any/all phone numbers, including cell numbers (by phone call or text message) and email addresses, for the purpose of treatment, scheduling, insurance, or payment.

_____ ***(please initial)*** If applicable, I authorize use of this form on all my insurance submissions, and I authorize the release of information to all my insurance companies. I understand that I am responsible for my bill. I authorize Tomblyn Family Orthodontics to act as my agent in helping me to obtain payment from my insurance companies. I authorize payment to Tomblyn Family Orthodontics, and I permit a copy of this authorization to be used in place of the original.

_____ ***(please initial)*** I grant the right to Tomblyn Family Orthodontics to release the patient's dental and/or medical histories and other information about the patient's treatment to third-party payers and/or other healthcare professionals.

_____ RECORDS RELEASE / VISITS:

- *Other than yourself*, please list any parties (parent/guardian, stepparents, spouse, or other family) to whom we may provide protected health information should it be requested:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

PHOTO CONSENT

Tomblyn Family Orthodontics on occasion takes photos and videos of patients to be used in the office, on the website, other social media, and related publications. This list is not inclusive but serves to demonstrate situations in which patients might be photographed, (please initial one)

_____ YES, I give permission to display photo(s) or video(s) of the patient in association with TFO events, functions, or publications.

_____ NO, I request that photo(s) or video(s) of the patient NOT be displayed in association with TFO events, functions or publications.

_____ _____

Signature of Patient or Legal Guardian | Regarding Patient(s)

_____ _____

Relationship to Patient | Date