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CHILDREN + TEENS + ADULTS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient's Legal Name: _____

Section B: To the Patient – Please Read these Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request with this Consent. We encourage you to read it carefully and completely before signing this consent.

Office Procedures: As a part of the practice procedures our doctors reserve the right to use patient photographs, x-rays, videos and other photographic reproductions for the purpose of professional academic education and practice promotion, including use on website, brochures and social media sites.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will make available upon request a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revision of our Notice, at any time by contacting:

Contact Person	Traci Havens
Telephone	850-659-7599
Email	info@bowmandmd.com
Address	28 Racetrack Rd, Fort Walton Beach, FL 32547

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice or your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Section C: Signature

Patient/Parent Signature _____ Today's Date _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT



28 Racetrack Road, NW
Fort Walton Beach, FL 32548
bowmandmd.com

908 S Palm Blvd
Niceville, FL 32548
850-863-2122

