Pediatric Dentistry &
Family Orthodontics

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HIPAA CONSENT

Patient Name

I give this practice/clinic my consent to use or disclose my or my child's protected health information to carry out my treatment, to confirm appointments, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also, understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print your name: _____
Patient, parent, or legal guardian

Your Signature: _____
Patient, parent, or legal guardian

Date:_____

If signed by a patient representative, state the relationship to the patient _____.