CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Parent Giving Consent (HIPAA)

Patient(s) Name(s): _____DOB: _____

Section B: To the Parent – Please Read the Following Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your child's 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, healthcare operations, uses and disclosures we may make about your child's protected health information, and other important matters about your child's protected health information.

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 issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. You may obtain a copy of our Notice of Privacy Practices at any time, including any revisions of our Notice, by contacting:

Cedarfield Dental, PLLC
325 West Street, Canandaigua, NY 14424
Phone: 585-394-4058
E-mail: Canandaigua.peds.dentist@gmail.com

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

Signature:

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 child's protected health information to carry out treatment, payment activities, and healthcare operations.

Parent/Guardian Signature: _____Date:_____

Parent/Guardian Printed Name:_____Relationship to Patient:_____

Please list anyone else (other parent, family members) to whom we can speak regarding the patient's care:

1.)_____Relationship: _____

2.)_____Relationship: _____

3.)_____Relationship: _____