



HIPAA Consent Form

Welcome to Smile Garden Pediatric Dentistry!

NOTICE OF PRIVACY PRACTICES

Patient Name _____ Birthdate: _____

Patient Name _____ Birthdate: _____

Patient Name _____ Birthdate: _____

Patient Name _____ Birthdate: _____

The department of Health and Human Services has established this "Privacy Notice" to help ensure that personal health information is protected for privacy. It was also created to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment and payment of health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We adhere to reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information only to those we feel need information about your child/children's treatment, payment, or health care operations, to provide health care that is in his/her/their best interest.

I understand that by signing this consent, I authorize Smile Garden Pediatric Dentistry to use and disclose my child's private health information to carry out the following:

- Treatment (including direct or indirect treatment by other health care providers involving treatment)
- Obtaining payment information from third parties (i.e. my insurance company)
- The daily healthcare operations of this practice

I have read and understand my rights given to me under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I understand that I have the right to refuse consent to the use or disclosure of my child's protected health information in writing. In turn, Smile Garden Pediatric Dentistry has the right to decline treatment of my child/children if I decline consent to disclose my child/children's Personal Health Information (PHI). I understand that I can revoke this consent in writing at any time. Any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I have received a copy of the Privacy Practices for Smile Garden Pediatric Dentistry.

Signature of Parent/Legal Guardian: _____ Date: _____

Printed Name of Parent/Legal Guardian: _____ Relationship: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of the Privacy Practices, but acknowledgement could not be obtained because:

- _____ Individual refused to sign.
- _____ Communication barriers prohibited obtaining the acknowledgement.
- _____ An emergency situation prevented us from obtaining acknowledgement.
- _____ Other _____