KIDS PEDIATRIC DENTISTRY, PA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you 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, and healthcare operations, of the uses and disclosures of your child's protected health information, and of other important matters about your child's protected health information. A copy of our Notice of Privacy Practices is available for review at your request. We encourage you to read it carefully and completely before signing this Consent.

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.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address 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.

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

Practice: **KIDS PEDIATRIC DENTISTRY, PA**

Address: **335 N ALLEN DRIVE, ALLEN, TEXAS 75013**

Telephone: **972-727-0011** Fax: **972-727-0707**

E-mail: **info@kidspediatricdentistry.com**

SECTION B: CONSENT

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

Patient's Name: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.