dentistry for children

HIPAA CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly (i.e., orthodontists or oral surgeons).
- Obtain payment from your insurance company.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Remind you of upcoming appointments, treatment options, or alternatives.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to address below to obtain a current copy of the *Notice of Privacy Practices.*

Dentistry For Children
651 E. Parkcenter Boulevard, Boise, ID 83706
2320 E. Gala Street, Suite 100, Meridian, ID 83642

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name(s): ____

Signature (Parent or Guardian): __________________________________

Relationship to Patient: ____________________ Date: ______________