everyone by one
pediatric dentistry

PRIVACY PRACTICE (HIPAA) CONSENT FORM

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a copy of the Statement of Privacy Practices (HIPAA Compliance) for Everyone By One. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my child's treatment, payment for services or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to mine and my child's protected health information. The Statement of Privacy Practices is also posted in the facility.

Everyone By One reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be emailed to me. This consent will remain in effect until terminated by me in writing.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of mine or my child's protected health information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY ○ YES ○ NO

SPOUSE ONLY ○ YES ○ NO

OTHER (PLEASE SPECIFY) _____

PATIENTS NAMES

PARENT / LEGAL GUARDIAN SIGNATURE

PRINTED NAME _____ SIGNATURE _____

RELATIONSHIP TO PATIENT(S) _____ DATE _____

OFFICE USE ONLY

Record of Acknowledgement Not Obtained

Provided Prior to Treatment ○ YES ○ NO

Reason for Denial:
- ○ Needed more time to review Statement of Privacy Practices
- ○ Wanted to consult with another person before signing
- ○ Unable to sign
- ○ Reason not given

Other (Explain): _____