ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

HIPAA

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Smile Surfers. The statement of Privacy Practices describes the types of uses and disclosers of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Smile Surfers reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If 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 mailed or otherwise transmitted to me.

Name of patient(s):

1. _____ 2._____

3._____ 4. _____

5. _____ 6. _____

MINOR CONSENT/DISCLOSURE AUTHORIZATION

The **Consent** box below gives authorization to consent to any radiographs, examination, anesthetic, medical, or any dental diagnosis and or treatment to be rendered to the minor(s) under the general or specific supervision and on the advice of any dentist licensed to practice.

The **Discuss Medical/Financial** box below gives authorization to disclose my Protected Healthcare information to the persons identifies below.

This authorization shall be effective from the date signed below or until otherwise notified by the parent/legal guardian.

I/We hereby give permission to: (other than legal guardian)

Name:_____ Relationship to Patient:_____ ☐ Consent ☐ Discuss Medical/Financial

Name:_____ Relationship to Patient:_____ ☐ Consent ☐ Discuss Medical/Financial

Name:_____ Relationship to Patient:_____ ☐ Consent ☐ Discuss Medical/Financial

AUTORIZING SIGNATURE

Parent/Guardian Signature:_____ **Date:**_____

Relationship to patient: ☐ Parent/Guardian ☐ Self ☐ Power of Attorney ☐ Other:_____