KidZaam™ Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A:

PATIENT NAME: _____

PATIENT DOB: _____

SECTION B: TO THE PARENT OR GUARDIAN- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your 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 we may make of your protected health information, and of other important matters about your protected health information. 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 protected health information that we maintain.

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

Contact Person: KidZaam Dentistry Manager
Telephone: 928-443-1400
Address: 2801 North Pleasant View Drive
Prescott Valley, AZ 86314

Right to Revoke: You will have the right to revoke this consent at anytime by giving us written notice of you revocation submitted to the contact person 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.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your
(Print Parent or Guardian Name)
Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Relationship to Patient:_____

Date: _____

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

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REVOCATION OF CONSENT

I, _____, revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and health care operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature of Parent/Guardian: _____ Relationship: _____

Date: _____

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This form is educational only, does not constitute legal advice, and covers only federal, not state, law. (August 14, 2002)

Treatment Authorization

If you would like to give permission to another person to sign and authorize consent/financial forms for an examination or treatment, please list them below and include their relationship to the patient.

Child's Name: _____

Name	**Relationship**	**Updated** **Date**	**Initials**

_____ _____

Signature of Parent or Legal Guardian **Date**

_____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____

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