CONSENT/AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I give Burns Dental Care authorization to share dental findings and discuss my dental problems with the following person(s): _____.

Patient's Signature: _____ Date: _____

MINOR TREATMENT AUTHORIZATION

I give Burns Dental Care authorization to evaluate and provide necessary treatment to my child. I further authorize the following person(s) to seek treatment from Burns Dental Care for my child: _____.

Patient's Signature: _____ Date: _____

HIPPA PRIVACY POLICY

By signing this form, you consent to use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, if so we will issue a revised notice.

I acknowledge that I have been given a copy of Burns Dental Care's Privacy Policy.

Patient's Signature: _____ Date: _____

RIGHT TO REVOKE

You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact officer. Please understand that revocation of this consent will not affect any action we took in the 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.

Your are entitled to a copy of this consent after you sign it

Patient's Signature: _____

Printed Name: _____ Date: _____