michele boyne
PEDIATRIC DENTISTRY

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME: _____ _____

PARENT NAME: _____
ADDRESS: _____
TELEPHONE: _____SS#:_____

TO THE PARENT/GUARDIAN - PLEASE READ THE FOLLOWING 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. You may request a copy of our notice prior to signing this form. Our Notice provides a description of our treatment, payment activities, and of other important matters about your protected health information.
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 Dr. Michele Boyne. Please understand the 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 your child or to continue treatment if you revoke this Consent

We reserve the right to change our privacy practices as described in our Notice of Privacy Pract6ices. 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 or 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 Dr. Michele Boyne.

SIGNATURE:
I, _____, have had full opportunity to read and consider the contents of this Consent form and your 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: _____DATE: _____
RELATIONSHIP TO PATIENT: _____

YOU ARE ENTITILED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

FOR OFFICE USE ONLY

_____ INDIVIDUAL REFUSED TO SIGN
_____ COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
_____ AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENTS
_____ OTHER _____