Authorization Consent Form/HIPAA Privacy Notices

Last Name: _____ First Name: Birthdate:

Medical Records Release:

I agree to the release of any records and photos necessary for treatment, referral, billing, or insurance purposes. These records may need to be shared with other clinical providers for treatment purposes as well.

Yes No

☐ ☐ Initials

Photo Release:

I hereby release photos of myself (or my child) taken by Designing Smiles for promotional purposes and materials including the Designing Smiles website.

Yes No

☐ ☐ Initials

Treatment Authorization for a child/minor:

If a parent or guardian is unable to be present for treatment to be performed, I authorize staff at Designing Smiles to perform the necessary procedures as agreed upon per veral or written consent including, but not limited to, Radiographs (Xrays), Fluoride treatment,and sealants.

Yes No

☐ ☐ Initials

Clinical Information Release Authorization:

I authorize Designing Smiles to disclose/discuss my clinical records and treatment with my parent/guardians. I understand that I have the right to revoke this authorization, in writing, at any time.

Yes No

☐ ☐ Initials

I, _____, have had full opportunity to read and consider the contents of this consent form and 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 in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

By signing this form, you are assuming responsibility for all charges regardless of insurance coverage.

Patient/Parent/Guardian Signature: _____

Date: