LUMBERTON
Pediatric Dentistry

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

(1) Conduct, plan and direct my child's treatment and follow–up among the multiple healthcare providers who may be involved in that treatment directly or indirectly

(2) Obtain payment from third-party payers

(3) Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my child's health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my child's private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions; however, if you agree then you are bound to abide by such restrictions. I understand I have the right to revoke this consent except to the extent that we have already taken action covered under this consent. If I chose to revoke this consent, I must do it in writing.

Contact Information:

Patient's Name:_____

May we call you at: Home: Yes / No Work: Yes / No Cell: Yes / No

Please list persons with whom we may we discuss your child's health information:

_____

_____

Please list persons to who we may release medical information, including picking up

prescriptions: _____

_____

_____ _____

Signature of Parent/Guardian Relationship Date