CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

(Government regulations regarding privacy require that this form be read and signed before we can treat your child. We apologize for your inconvenience and appreciate your cooperation. Thank you)

Patient Name _____

PARENT OR GUARDIAN GIVING CONSENT

Parent Name (or guardian): _____

Address: _____

Telephone: _____ Social Security # _____

SECTION B: 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. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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: **RONALD J. GARZA DDS, MS**
Telephone: **972-564-2222** Fax: **972-564-2322**
Address: **215 S. FM 548, Suite B, Forney, TX 75126**

I give my consent and authorization to Just For Kids Dentistry of Forney:

1. **To release a school or work excuse for dental visits upon request.**
2. **To automatically mail appointment reminder postcards and leave messages on my telephone answering machines.**

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 from 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: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

Right to Revoke: You will have the right to deny Consent or to revoke your Consent at any time by giving us written notice of your 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 deny or this Consent.

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____

YOU ARE ENTITLED (ON REQUEST) TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign.

___ Communications barriers prohibited obtaining the acknowledgement

___ An Emergency situation prevented us from obtaining the acknowledgement

___ Other (please specify) _____