WILDEY
PEDIATRIC DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

TO THE PATIENT/GUARDIAN—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.

I authorize Wildey Pediatric Dentistry to communicate with outside dentists, physicians, pharmacies, insurance companies, and or their staffs, and/or any other health care professional, concerning my medical/dental health care and my billing/account records held by Wildey Pediatric Dentistry. I further authorize the electronic, digital, or verbal communication of records or information between Wildey Pediatric Dentistry and any of the above mentioned entities associated with dental treatment. All treatments, accidents, and or illnesses are covered by this release. I agree to hold harmless the doctors, staff, officers of Wildey Pediatric Dentistry concerning the release of any dental/medical records.

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 Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jennifer Wildey – (210) 417-4181, (855) 700-9283 – e-mail: happyteeth@wildeypd.com

Address: 10003 NW Military Hwy, Suite 3201, San Antonio, TX 78231

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 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 to treating you if you revoke this Consent.

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: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Guardian's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.