JACLYN S. MARTIN, D.D.S., M.S.

Janesville Pediatric Dental Care

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Authorization for Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review the Notice, in full, before signing this consent.

You have the right to request that we restrict how protected health information about your child is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your child for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Art of 1996 (HIPPA).

It is Understood that:

*Protected health information may be disclosed or used for treatment, payment or health care operations.
*The Practice has a Notice of Privacy Practices packet and I have the right to review it if requested.
*The patient's legal representative has the right to restrict the uses of information but the Practice does not have to agree to those restrictions.
*The patient's legal representative may revoke this consent in writing at any time and all future disclosures will then cease.
*The Practice may condition treatment upon the execution of this consent.

Print Name of Patient(s):_____

Signature of Legal Representative:_____

Relationship to Child:_____

( ) Individual refused to sign _____Staff Member & Date