CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Patient DOB**:_____
As part of your healthcare, this practice originates and maintains paper and/or electronic record describing your health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your care
- Submit your diagnosis and treatment information for payment from insurance companies or others

By signing this document, and "only as permitted by State or Federal law", you are giving this practice your consent to do the following:

- **To disclose, as may be necessary, your health information to other healthcare providers (such as, referrals to or consultation with other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.**
- **To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment**
- **To submit your diagnosis and treatment information to insurance company(s), other agencies and/or individual(s) for payment of services**
- **Leave appointment reminders or information, we believe necessary for treatment or payment, with a family member or on an answering machine. The information, will be the minimum necessary in our professional judgment**
- **Discuss your health information (only as necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments**
- **Please list by name and relationship any person with whom we may not share your health or payment information (based on professional judgment, this practice has the right to not honor your request)**

We will make available to you, at your request, our **"Notice of Privacy Practice"** that provides a more complete description of health information uses and disclosures, which is outlined above, as required by the HIPAA standard.

You may request a copy of our Notice of Privacy Practices by contacting our office
Contact name: Kattie Franks
813-968-2483
Email: k.franks@bluewavedentalgroup.com

I have read the Consent Form and I understand by signing this form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activity, and health care operations

_____	_____	_____
Signature	**Print name of person signing**	**Date**

*If other than a patient is signing, are you the parent, legal guardian, and legal custodian or have Power of Attorney for treatment and/or payment for this patient. Yes [ ] No [ ]
RELATIONSHIP_____.
If you are not the parent, please provide a copy of your legal authority for this patient.

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CHILD'S NAME: _____ **DOB:** _____

I (We) the parent (s) or legal guardian (s) authorize the individual (s) named below to act in my (our) behalf with the full authority to grant permission for any dental treatment or procedure that is in the best interest of the above named child in the opinion of the DGBW providers, licensed to practice in the State of Florida. In addition, the provider is hereby authorized in an emergent situation to perform whatever acts that in his/her professional opinion are in the best interest of the above-mentioned child. I understand that the provider may request to contact the parent/guardian prior to providing dental treatment even though this consent is presented. I understand that as parent(s) or legal guardian(s) that I am financially responsible for all care received as a result of this consent.

ADULTS THAT MAY SIGN FOR DENTAL TREATMENT IN MY (OUR) ABSENCE:

Name: _____ **Phone # :** _____

Address: _____

Name: _____ **Phone # :** _____

Address: _____

Name: _____ **Phone # :** _____

Address: _____

ADULTS THAT ARE NOT AUTHORIZED TO SIGN FOR DENTAL TREATMENT:
List anyone who is not authorized to sign for treatment in the event of divorce/legal custody matters.

Name: _____ **Name:** _____

This consent form will be in effect for 12 months from signing or less time if specified: _____

AUTHORIZED BY: (Both parents signature preferred, but not required)
By signing below, I certify that I am the legal parent or guardian of the child identified above and am acting within my authority in signing this consent form.

Mother (Printed): _____ **Witness:** _____

Signature:_____ **Date:** _____

Father (Printed): _____ **Witness:** _____

Signature:_____ **Date:** _____

Or Legal guardian (Printed): _____ **Witness:** _____

Legal guardian Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

[ ] "Consent form" reviewed by (employee) _____ on (date) _____

[ ] Patient refused to sign the consent form. Reason for patient refusal to sign _____

[ ] Restrictions added by the patient (see restrictions listed on front page)