PetitSmiles
PEDIATRIC DENTISTRY

Authorization for Disclosure of Health Information

Today's Date: .....
month/day/year

Patient's Name: ..... Date of Birth: .....
First Last month/day/year

Purpose: This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the notice from the patient. We must also have the notice available at the office for patients to request to take with them. We must post the notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the notice. Whenever the notice is revised, we must make the notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the notice to each new patient at the time of service delivery and to any person requesting a notice. We must also post the revised notice in our office as discussed above.

Notice of privacy practices: Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected healthcare information, and of other important matters about your protected health information.
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 practice at any time by contacting:

Phone:	*Address:*
(800) 895-1570	1535 Sunset Drive Coral Gables, FL 33143

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 address 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 if you revoke this consent.

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 healthcare operations.

Signature: ..... Relationship to patient: .....

Date: .....