Trussville Pediatric Dentistry
4901 Deerfoot Parkway, Suite 101
Trussville, AL 35173
(205) 655-1000

Patient Consent Forms

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996(HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
- Obtaining payment from third party payers(e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I understand that you reserve the right to change the term of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction,

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date, I revoke this consent is not affected.

Signed this _____day of_____, 20_____

Patient's Name_____

Signature of Parent/Guardian _____