HIPAA ACKNOWLEDGMENT AND CONSENT FORM

The federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

At times it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment and Consent

Please sign this form below to acknowledge that you have today been offered a copy of our Notice of Privacy Practices and consent to disclosures of your information that we deem necessary to provide your child or children with proper treatment.

I acknowledge that I have today been offered a copy of your Notice of Privacy Practices.

I consent to disclosures of my child's information, which you deem necessary, in connection with my child's treatment. I understand that such disclosures may not be of the type listed above.

_____	_____	_____
Parent/Guardian Signature	Print Parent or Guardian Name	Date