HIPAA Acknowledgement and Consent, Limited Authorization and Release Form

Patient Name: John S Doe **Birth Date:** 10/14/2015

By providing email addresses and cell phone numbers, I agree to be contacted via email and text message to confirm/schedule appointments and receive billing statements. Additional methods may include: home phone, work phone, and any voicemail. If none of these methods are available, I understand that paper copies may be mailed to my home address.	No
I agree that my child's health information may be conveyed electronically to any person involved in his/her medical/dental care, for payment of his/her care and submitting insurance/billing information.	No
I understand if I send information or pictures of my child via text/email directly to a doctor or to Camp Smile Pediatric Dentistry it is not encrypted, unless I have used an application to encrypt the text/email.	No

Please list any parties other than the parent or legal guardian who can bring your child(ren) to their appointments and can have access to their health information: This includes stepparents, grandparents, and any caretakers who can have access to this patient's records, must be 19 Y.O or older.

1. Name, Relationship, and Phone number	No
2. Name, Relationship and Phone Number	No
3. Name, Relationship, and Phone Number	No
4. Name, Relationship, and Phone Number	No

Please list any parties other than the parent or legal guardian who can give verbal and written consent for dental treatment.

1. Name, Relationship, and Phone Number	No
2. Name, Relationship, and Phone Number	**YES**
3. Name, Relationship, and Phone Number	No
4. Name, Relationship, and Phone Number	No

You may refuse to sign this acknowledgement and authorization. In refusing we *may not be allowed* to process your insurance claims.

The undersigned acknowledges receipt or understanding of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

****MY SIGNATURE WILL ALSO SERVE AS A PUBLIC HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE****

Signature

Date of signing	10/14/2024
Signature Of	Parent or Guardian
Name	Jane Roe
IP Address	127.0.0.1

Signature

Date of signing	10/14/2024
Relationship to the patient	Guardian
Name	Jane Roe
IP Address	127.0.0.1