



HIPAA Consent

I give Cute Smiles 4 Kids my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I understand that Cute Smiles 4 Kids has the right to change their privacy practices and that I may obtain any revised notices from the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that Cute Smiles 4 Kids is not required to agree to the request. If Cute Smiles 4 Kids agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I have reviewed the Notice of Privacy Practices.

Name of Patient:

(Please Print — Last Name / First Name)



Patient / Guardian Signature:

Date: / /

If signed by a parent or patient representative, state relationship to patient: