PARKVILLE DENTAL CENTER
6320 Lakecrest Lane
Parkville, MO 64152

PRIVACY POLICY NOTICE

I acknowledge that I have been given a copy of PARKVILLE DENTAL CENTER'S privacy policy.

Signature:_________________________________ Date: ____________________

CONSENT/AUTHORIZATION FOR USE and DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, if so we will issue a revised notice.

Signature: _________________________________ Date: ____________________

I give PARKVILLE DENTAL CENTER authorization to give dental findings and discuss my dental problems with the following person(s) ______________________________

Signature: _________________________________ Date: ____________________

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 Contact Officer. 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 or to continue treating you if you revoke this Consent.

MINOR TREATMENT AUTHORIZATION

I give PARKVILLE DENTAL CENTER authorization to treat my child. I further authorize the following person (s) to seek treatment from PARKVILLE DENTAL CENTER for my child ______________________________.

Signature: ____________________________ Date: _________________________

Relationship to patient: ____

Personal Representative's name: _______________________________________

You are entitled to a copy of this consent after you sign it.