Frederick KiDDS
Pediatric Dentistry

Privacy Act

Patient(s) Name and Date(s) of Birth

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I have read and understand my rights given to my under the Health Insurance Portability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Frederick KiDDS Pediatric Dentistry to use and disclose my private health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involving my treatment)
- Obtaining payment information from third parties (e. g. my insurance company)
- The day to day healthcare operations of Frederick KiDDS Pediatric Dentistry

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 operation, but Frederick KiDDS Pediatric Dentistry is not required to agree to these requested restrictions. However, if Frederick KiDDS Pediatric Dentistry does agree, they are bound to comply with this restriction. I understand that I can 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.

Initals_____

Friends and Family Consent

I give consent for the following family members and friends to accompany the child/ren listed above to his/her dental appointments and to act on my behalf to give consent for any dental or diagnostic treatment. I also give permission for the following people to receive private information about my child/ren regarding treatment, dental conditions and health history as it pertains to the dental visit. I further understand that whoever should bring my child to his /her appointment will be responsible for payment at the time services are rendered.

I may be reached at (phone number)_____ should any questions arise.
Initials_____
Family/ Friend Name_____ Relationship to patient_____
Family/ Friend Name_____ Relationship to patient_____

Social Media

I hereby give consent for Frederick KiDDS Pediatric Dentistry to use my child/ren's photograph and likeness in all forms of social media and any other lawful purpose pertaining to Frederick KiDDS Pediatric Dentistry.

Initials_____

Parent / Guardian signature_____ Date_____

Relationship to patient_____