Pediatric Dentistry of Poughkeepsie, PLLC
243 North Road, Suite 1B Poughkeepsie, NY 12601

HIPAA Notification and Consent to Treat a Minor

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
I understand that my signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third-party payers (e.g. my insurance company)
- The day-to-day healthcare operation of our practice

I have also been informed of and given the right to review and secure a copy of our Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that this practice reserves the right to change the terms of this notice from time to time, and that I may contact the office at any time to obtain the most current copy of this notice.
I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may 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.

Permission to Treat

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or legal guardian before any, and all necessary dental services can be performed by Doctor Noskow or any other doctor employed by Pediatric Dentistry of Poughkeepsie, PLLC. I, being the parent or legal guardian of the above minor patient, do authorize and request the performance of dental services for this patient; and the performance of whatever procedures the treating doctor at Pediatric Dentistry of Poughkeepsie, PLLC may deem necessary during the performance of any procedures. Furthermore, I will be responsible financially for any bill incurred for this patient for dental treatment; including any attorney or court fees in the even it becomes necessary to place this account in collectibles.

_____ _____
Signed/Relationship Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

__ Individual refused to sign
__ Communications barriers prohibited obtaining acknowledgment
__ An emergency situation prevented us from obtaining acknowledgment
__ Other (Please specify)

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