Bellaire Pediatric Dentistry, P.A.
"Oral healthcare for the growing & developing child"
6750 West Loop South, Ste. 795
Bellaire, TX 77401
713-661-1100

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient Name: ____

Parent/Guardian: ____

Address: ____

Telephone: _______________________ E-mail: ___________________________________

Section B: To The Patient—Please Read The Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Glenda Cornell or Joann Delattre

Telephone: 713-661-1100 **Fax:** 713-661-1385

Address: 6750 W. Loop South, Ste. 795 Bellaire, TX 77401

Signature

I, _________________________________, parent/guardian to ______________________________, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations.

Signature: _____________________________________ Date: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.