ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

HIPAA

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Smile Surfers. The statement of Privacy Practices describes the types of uses and disclosers of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Smile Surfers reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

Name of patient(s):

1. _____ 2._____

3._____ 4. _____

5. _____ 6. _____

AUTHORIZED ADULTS FOR APPOINTMENTS & INFORMATION SHARING

Complete this section only if someone other than a parent or legal guardian may bring your child to dental appointments, consent to treatment, or discuss medical/financial information on your behalf (for example: a grandparent, aunt, uncle, babysitter, or caregiver).

The individuals listed below are authorized to:

- Bring the child to dental appointments
- Consent to routine dental treatment and radiographs when necessary
- Discuss the child's treatment, scheduling, and/or financial information as indicated

This authorization remains in effect until revoked in writing by the parent or legal guardian.

I/We authorize the following individual(s):

Name	Relationship to Patient	May consent to Treatment	Discuss Medical/Financial Infomation
_____	_____	☐ Yes	☐ Yes
_____	_____	☐ Yes	☐ Yes
_____	_____	☐ Yes	☐ Yes

AUTHORIZING SIGNATURE

Parent/Guardian Signature: _____ **Date:** _____

Relationship to patient: ☐ Parent/Guardian ☐ Self ☐ Power of Attorney ☐ Other:_____