4132 Arkwright Road, Macon, Georgia, 31210

Office: (478)405-7797 Fax: (478)405-7794

E-mail: jacobspediatricdentistry@aol.com

Office Contact Person: Kimberly Bumgardner

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name:____

Purpose of consent: 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.

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 of Privacy Practices 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 of Privacy Practices accompanies this consent.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat your child/children if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Please send this note to the office contact person listed at the top of this form.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD/CHILDREN'S HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Date:____

Parent/Guardian Signature:____