Heidi J. Stark
Diplomate, American Board of Pediatric Dentistry
Libby A. Johnson
Diplomate, American Board of Pediatric Dentistry
Emily J. Egley
Diplomate, American Board of Pediatric Dentistry
Katie J. Garcia
Diplomate, American Board of Pediatric Dentistry

HIPAA Acknowledgement And Consent, Limited Authorization And Release Form

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

☐ By providing email addresses and cell phone numbers, I agree to be contacted via email and text message to confirm/schedule appointments and receive billing statements. Additional methods may include: home phone, work phone, and any voicemail. If none of these methods are available, I understand that paper copies may be mailed to my home address.

☐ I agree that my child's health information may be conveyed electronically to any person involved in his/her medical/dental care, for payment of his/her care and submitting insurance/billing information.

PLEASE LIST ANY PARTIES OTHER THAN THE PARENT OR GUARDIAN WHO CAN BRING YOUR CHILD(REN) TO THEIR APPOINTMENTS AND CAN HAVE ACCESS TO THEIR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records)

Name: ______________________ Relationship: ______________________ Phone#: ______________________

Name: ______________________ Relationship: ______________________ Phone#: ______________________

Name: ______________________ Relationship: ______________________ Phone#: ______________________

Name: ______________________ Relationship: ______________________ Phone#: ______________________

The undersigned acknowledges receipt or understanding of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

****MY SIGNATURE WILL ALSO SERVE AS A PUBLIC HEALTH INFORMATION DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE****

______________________ ______________________

Please ***print*** name of Parent or Guardiant | Please ***print*** name of Patient(s)

______________________ ______________________ Date: ____________

Signature of Parent/Guardiant | Relationship to Patient

Office Use Only

We attempted to obtain the parent/guardian's signature on this Acknowledgement but did not because:

An emergency situation prevented consent ________

Communication barrier with the patient ________

Individual refused to sign ________

Other (please describe) ________ ______________________

Signature of Lincoln Pediatric Dentistry Staff