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Diplomate, American Board of Pediatric Dentistry
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Diplomate, American Board of Pediatric Dentistry
Allie L Wolf, DDS

LINCOLN 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

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