LINCOLN PEDIATRIC DENTISTRY

HIPAA Acknowledgement And Consent, Limited Authorization And Release Form

- ☐ 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.
- ☐ I understand if I send information or pictures of my child via text/email directly to a doctor or to Lincoln Pediatric Dentistry it is not encrypted, unless I have used an application to encrypt the text/email.

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 stepparents, grandparents and any caretakers who can have access to this patient's records.) MUST BE 19 Y.O. OR OLDER.

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

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

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 Guardian | Please **print** name of Patient(s)

_____ _____

Signature or Parent/Guardian | 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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East Office 7001 A St., #103 Lincoln, NE 68510 | **Yankee Hill Office** 3811 Grainger Pkwy Lincoln, NE 68516

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