

Dr. Duga Dr. Feeney & Associates
Pediatric Dentistry

15293 Amberly Drive
Tampa, Florida 33647
(813) 631-1100

Authorization for Use and Disclosure of Protected Health Information

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about your child. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about your child is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your child for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

It is understood that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and you have had the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient's legal representative has the right to restrict the uses of information but the Practice does not have to agree to those restrictions.
- The patient's legal representative may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Other than described above, individual to whom information may be given regarding your child's medical records:

Print Name of Patient _____

Signature _____ Date _____

Relationship _____

Witness _____ Date _____