GUADALUPE KIDS DENTAL

751 Best Drive, Suite D
Seguin, Texas 78155
830-209-7262 • 830-209-7263

NOTICE OF PRIVACY PRACTICE

Patient's Full Name: _____

Date of Birth:_____ Parent/Guardian Name:_____

PATIENT CONSENT FOR DENTIST TO USE OR DISCLOSE HEALTH CARE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE.

I UNDERSTAND THAT MY CHILD/CHILDREN'S HEALTH INFORMATION IS PRIVATE AND CONFIDENTIAL. I UNDERSTAND THAT Dr. Kristopher Bennion, DMD, WORKS VERY HARD TO PROTECT MY PRIVACY AND PRESERVE THE CONFIDENTIALITY OF MY CHILD/CHILDREN'S HEALTH INFORMATION.

I UNDERSTAND THAT SIGNING THIS DOCUMENT MEANS THAT Dr. Kristopher Bennion, DMD, MAY USE AND DISCLOSE MY CHILD/CHILDREN'S HEALTH INFORMATION TO HELP PROVIDE HEALTH CARE TO MY CHILD/CHILDREN, HANDLE BILLING AND PAYMENT, AND TAKE CARE OF OTHER HEALTH CARE OPERATIONS. FAILURE TO SIGN THIS CONSENT MAY RESULT IN THE DENTIST DECLINING TO TREAT MY CHILD/CHILDREN.

UNDER THE TERMS OF THIS CONSENT, I CAN ASK Dr. Kristopher Bennion, DMD, TO RESTRICT HOW MY CHILD/CHILDREN'S HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. I UNDERSTAND THAT Dr. Kristopher Bennion, DMD, DOES NOT HAVE TO AGREE TO MY REQUEST. IF HE DOES AGREE TO MY REQUEST, I UNDERSTAND THAT HE WOULD FOLLOW THE AGREED LIMITS.

I UNDERSTAND THAT I HAVE THE RIGHT TO CANCEL THIS CONSENT IN WRITING AT ANY TIME. IF I DO CANCEL THE CONSENT, I UNDERSTAND THAT Dr. Kristopher Bennion, DMD, MAY HAVE ALREADY USED OR DISCLOSED INFORMATION ABOUT MY CHILD/CHILDREN, AND CANCELING THIS CONSENT WOULD NOT AFFECT THE INFORMATION ALREADY USED OR DISCLOSED.

I MAY CANCEL THIS CONSENT AT ANY TIME BY DOING THE FOLLOWING:

WRITING, SIGNING, AND DATING A LETTER TO Dr. Kristopher Bennion, DMD, THAT SAYS I WANT TO REVOKE MY CONSENT TO AUTHORIZE THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPTIONS.

I UNDERSTAND IF I CANCEL THIS CONSENT, Dr. Kristopher Bennion, DMD, IS NOT OBLIGATED TO PROVIDE FURTHER HEALTH CARE SERVICES TO MY CHILD/CHILDREN.

TO GIVE CONSENT TO DISCLOSE HEALTH CARE INFORMATION TO SOMEONE OTHER THAN THE PATIENT, PLEASE WRITE THEIR NAME BELOW: (E.G. FAMILY MEMBER, CARETAKER) and RELATIONSHIP TO CHILD.

Name:_____

MY SIGNATURE BELOW INDICATES THAT I AGREE TO THE POLICIES OUTLINED BY THIS DOCUMENT AND ALL STATEMENTS THEREIN.

Parent Signature: _____Date:_____