Authorization Consent Form/HIPPA Privacy Notices

Last Name: ______________________ First Name: Birthdate:

Address: ______________________________ City __________ State: ___ Zip: ______

Home Phone: Cell Phone: Work Phone:

Email: info@smilesmn.com

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Text

Who may we thank for referring you to our office?

Medical Records Release:
I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.
Designing Smiles receives medical information on patients that may need to be shared with medical providers.
( ) yes ( ) no ________________initials

Photo Release:
I hereby release photos of myself (or my child) taken by Designing Smiles for promotional purposes and materials including the Designing Smiles website.
( ) yes ( ) no ________________initials

Treatment Authorization for a child/minor:
If a parent or guardian is unable to be present for treatment to be performed, I authorize staff at Designing Smiles to perform the necessary procedures as agreed upon per veral or written consent including, but not limited to, Radiographs (Xrays), Fluoride treatment,and sealants.
( ) yes ( ) no ________________initials

I, ____________________, have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

By signing this form, you are assuming responsibility for all charges regardless of insurance coverage.

Patient/Parent/Guardian Signature: ____

Date:____________________