Progressive Pediatric Dentists

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose of Consent: By signing this form , you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Individual giving consent:_____

Patient's Name:_____

I give consent for _____to as for or receive information about this child. If your wish to have a copy of the HIPPA notice, please ask at your dental visit.

Signature:_____Date_____