Ped Z Dental
Dr. Stacey Zaikoski, DDS

Patient Consent Form for Use or Disclosure of Patient's Protected Health Information

Name_____Date of Birth_____

I hereby authorize Ped Z Dental to release the following personal health information for:

___Dental Claims

___Prescription, diagnostic, treatment and/or management services

___Reviews required by HIPAA-compliant healthcare operations

___Other

The above information may be released by:

___Phone ___Fax ___Mail ___Friend or Relative

My Consent Effective: Today's Date_____

I want this consent to:

____Continue indefinitely ____Effective until_____(date)

I understand that consent may be revoked at any time. I understand why I have been asked to disclose this information and I am aware that my patients' rights are identified in the practice's Notice of Privacy Practices.

I_____, have received and reviewed a copy of Ped Z Dental's health information privacy and security Policies and procedures.

Signature of Patent or Parent/Guardian

X_____Date_____