RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient: Submitted: 10/17/2025

Patient Name / DOB / Today's Date

CONSENT AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly. *(Example: orthodontists or oral surgeons).*
- Obtain payment from your insurance company.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Remind you of upcoming appointments, treatment options, or alternatives.

I understand and consent to my medical information being used as described here.

I authorize the following person(s) to have access to information covered under the Privacy Practice regarding my child. *(Example: grandparent, step-parent, adult sibling, aunt/uncle)*

Name / Relationship to Patient			
Name / Relationship to Patient	Parent: [ ]	Guardian: [ ]	Other: [ ]
Name / Relationship to Patient	Parent: [ ]	Guardian: [ ]	Other: [ ]
Name / Relationship to Patient	Parent: [ ]	Guardian: [ ]	Other: [ ]

I understand the terms and authorize the practice to disclose my medical information to those parties as mentioned above.

I understand and acknowledge my rights as detailed in the Notice of Privacy presented here.

I have been given by Little Sunshine Pediatric Dentistry a copy of Notice of Privacy Practices containing a more complete description of the uses and disclosures of my child's health information to review prior to signing this consent.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy.

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By my signature below, I affirm the above information.

Name of Parent, Legal Guardian or Authorized Representative
Relationship to Patient
Signature