Consent for General Dental Treatment and HIPAA release Date:

Patient's Name: _____ Birthdate: _____

I give consent to receive preventative dental treatment deemed necessary by the providers at Gilbert Omido, DDS, PA. These procedures include, but are not limited to; **examinations, oral prophylaxes (cleanings), radiographs (x-rays), fluoride treatments, sealants, and periodontal (gum) treatments.** If further dental treatment is needed, this will be discussed prior and more detailed consent will be obtained.

I authorize Gilbert Omido, DDS, P.A. to discuss or release information identified in Paragrah 1 below to the following individuals:

| Name(s) of authorized person(s) | Relationship to patient |
|---|---|
| | |
| | |
| | |

**HIPAA**

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY"

New federal legislation, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), limits with whom we can discuss your health information. If there is a person or persons with whom you would like us to be able to discuss you or your dependent's health information, you ***must*** designate them below.

1. I authorize Gilbert Omido, DDS, P.A. to discuss or release information necessary for the purpose of treatment, coverage/benefit inquiries, claim inquiries, appeals, health care operations and/or questions about my health care and I acknowledge that the information released may include individually identifiable health information about me.
2. This authorization is being made at my request.
3. In signing this authorization, I understand and acknowledge the following:
    a. I understand that this authorization is voluntary and that I may refuse to sign it.
    b. I understand that my refusal to sign this authorization will not affect my ability to obtain treatment
    c. I understand that I may revoke this authorization at any time by notifying Gilbert Omido, D.D.S., P.A. in writing and all future disclosures will then cease. However, such revocation will not affect any disclosures we have already made based on your prior consent.
    d. I understand that once the disclosures authorized herein have been made, the information disclosed may be subject to re-disclosure by any recipient and no longer protected by federal privacy laws.
    e. I understand as a patient, I have a right to restrict the uses of this information but the Practice does not have to agree to these restrictions.
    f. I acknowledge that Gilbert Omido, DDS, P.A. provided me with a Notice of Privacy Practices.

_____ _____

Signature of patient Printed name of patient