375 South End Avenue, Suite B
New York, NY 10280
Call or Text: (212) 786-0930
Fax: (212) 656-1430
E-Mail: contact@batteryparkpediatricdentists.com

HIPAA Consent

Release of Information

Battery Park Pediatric Dentists may seek, release and verify all or part of the patient's dental and/or financial records to any person, corporation, or governmental agency which is or may be liable under a statute, regulation, or contract to the office, the patient, a family member, for all or part of Battery Park Pediatric Dentists charges.

Publications of Records

I authorize photos, slides and x-rays of my care and treatment during or after its completion to be used for the advancement of dentistry and for reimbursement purposes.

Medical Authorization to Release Information & Payment Request

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of dental or medical information about me to be released to the carriers for information needed for claims. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for dentists or organization to submit a claim to insurance for payment.

HIPPA

By signing this form you will consent to our use and disclosure of your health information to carry out treatment, paying activities, and healthcare operations. I have had full opportunity to read and consider the contents of this Consent form and your 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 to carry out treatment, paying activities and health care options.

We welcome you to our office and thank you for your reading, understanding and consenting to our policies.

Parent/Guardian Signature: _____

Parent/Guardian Name: _____

Relationship to patient: _____

Date: _____

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