Weber Dental
Family Dental Care
Because You Deserve a Healthy Smile

HIPAA Annual Consent / Authorizations

Patient Name: _____ DOB: _____

Consent for Treatment:

- Permission is hereby given for x-rays, study models, photographs or any other diagnostic aids to make a thorough diagnosis of the patient's dental needs. I also authorize Weber Dental to perform all forms of treatment, medication and therapy that may be indicated. I also understand that the use of anesthetic agents embodies a certain risk.
- In the case of an un-emancipated minor, the consent below is given on his or her behalf.

Consent to Release Information to a Spouse, Family Member or Significant Other:
Tell us with whom we may discuss your protected health information:

1) _____ 2) _____ 3) _____

If you do not authorize information to be released to anyone, please check this statement.

☐ **I do not authorize my information to be released to anyone other than myself.**

I hereby authorize message to be left on a voice mail system or answering machine. Please indicate the number Weber Dental can utilize to leave a message for you:

1) _____2) _____3) _____

Check one of the following:

___I give permission for Weber Dental to leave me a detailed message.
___Please leave me a message asking for a returned call.

Acknowledgment of Privacy Rights:
By signing below, I acknowledge that I am aware of the Weber Dental HIPAA Notice of Privacy Practices.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature: _____ **Date:** _____

Print Name: _____**Email address:** _____