Valeria Poggio, DDS, MS

891 Kuhn Dr Ste 205
Chula Vista, CA 91914
Tel. (619) 482-2412
Fax (619) 482-2442

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Responsible Party Name: ______________________________

Address: ______________________________

____

Telephone: Home: ____________________ Work/Cell: ____________________

Patient's Name: ______________________________

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Valeria Poggio, D.D.S., M.S.

Telephone: (619) 482-2412 Fax: (619) 482-2442

E-mail: office@drpoggio.com

Address: 891 Kuhn Drive, Suite 205, Chula Vista, California 91914

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, (PRINT NAME)______________________________, 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, payment activities and health care operations.

Signature: ______________________________ Date: ____________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ______________________________

Relationship to the Patient: ______________________________

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

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Authorization to Display Patient's Photographs/Video

We are developing a photo/video program for new patients that start treatment in our office. We are displaying our new patients' smiles in our office before the treatment is started and after it is completed. This is a fun way we can display your child's new and improved smile!
Initials: ________

We are posting pictures, videos and testimonials on our website and social media sites, where our patients can share the experience they've had in our office – whether it's proudly showing off their new braces, or showing off their beautiful new smiles after treatment!
Initials: _________

As of April 14, 2003, the new Federal and State laws require our office to comply with the key privacy aspects of the Health Insurance Portability and Accountability Act (HIPAA). We are now required to obtain the written permission from the patient, parents or the responsible party of patients in order to take photos or videos and display them. If you or your child would like to participate in the programs mentioned above, please initial giving us permission to display you or your child's photo, video and/or testimonial.

Signature of Responsible Party:______________________ Date:_______