CONSENT FOR RELEASE OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Dermody Pediatric Dentistry & Orthodontics, P.A. (hereby collectively referred to as "Practice") to use and disclose the entire medical record concerning _____ in accordance with the
Print Patient's Full Name

attached Notice of Privacy Practices (NOPP). I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

If we have super-confidential information that could include HIV/AIDS, alcohol and/or substance abuse diagnosis and treatment records, or psychotherapy records, I specifically authorize Practice to disclose this information verbally or by mail in accordance with the law.

_____
Print Full Name of Parent or Representative

_____ _____
Signature Date