# Summit Pediatric Dentistry

## Stephen B. Korson, DDS

NJ Specialty Permit #2643
115 Kent Place Boulevard
Summit, New Jersey 07901

Tel: 908-522-0640 Fax: 908-522-6677

*summitpediatricdentistry.com*


## PATIENT CONSENT FORM

I understand that I have rights to privacy regarding my protected health information. These rights are provided under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which went into effect on April 14, 2003. I understand that by signing this consent I authorize Summit Pediatric Dentistry, Dr. Korson and his staff to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in this treatment);
- Obtaining payment from third party payers (e.g. your insurance company);
- The day-to-day healthcare operations of the practice.

I have been informed of, and given the right to review and secure a copy of the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that Summit Pediatric Dentistry and Dr. Korson reserve the right to change the terms of this notice from time to time and that I may contact this office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions of how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that Summit Pediatric Dentistry and Dr. Korson are not required to agree to these requests. However, if the restrictions are agreed to then they must be complied with.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Signature: _____ Date: _____