Authorization of Release of Protected Health Information

By signing this document, you are allowing the Dental Foundation of Oregon Tooth Taxi staff to give or receive from other health care providers or child agencies your child's health care records to provide the best care for your child. The records may be sent to another dentist, dental specialist or other health care provider that the Tooth Taxi staff recommends further treat your child. The information may also be shared with an agency that your child is affiliated with (such as school, Head Start, etc.) for record keeping purposes.

Patient's Name _____

I hereby authorize:

Dental Foundation of Oregon- Tooth Taxi
PO Box 2448
Wilsonville OR 97070-2448

to receive from or release to the appropriate health care provider or agency, my child's records to facilitate his or her health care needs and/or treatments.

Name of parent/legal guardian_____
(please print)

Parent/legal guardian signature_____Date_____

If there are providers or agencies that you do NOT want your child's records released to or received from please list here:

_____ _____

HIPAA
Acknowledgement of Receipt of Notice of Privacy Practices

*****You May Refuse to Sign this Acknowledgment

Patient Name_____

I,_____
(parent/legal guardian name)

have received a copy of the Dental Foundation of Oregon's Tooth Taxi's Notice of Privacy Practices.

Parent/legal guardian signature
_____Date_____

**For Office Use only: ***We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because: __Individual refused to sign, __Communications barriers prohibited obtaining the acknowledgment, ___ An emergency situation prevented us from obtaining acknowledgment, __Other (Please Specify)