Sprouts Pediatric Dentistry

CONSENT AND LIMITED AUTHORIZATION TO RELEASE HEALTH INFORMATION

I agree that Sprouts Pediatric Dentistry (the "Practice") may use and disclose my personal and confidential health information in a manner consistent with the disclosures set forth in the Practice's Notice of Privacy Practices as well as the consents and authorizations set forth in this form.

******You may refuse to sign this form. However, by refusing to sign this form, the Practice may not be allowed to process claims with your insurance company******

Permitted Disclosures without Consent Under Federal and Minnesota Law

By signing this form, I acknowledge that the Practice may disclose my health information under the following circumstances without receiving my direct consent:

Representation From Provider: The Practice may disclose information when there is a representation from a provider that it holds a signed and dated consent from me authorizing the release, provided that the Practice documents:

- The provider requesting the dental records;
- My identity;
- The dental records requested; and
- The date the dental records were requested.

Specific Authorization in Law: The Practice may disclose my dental information without my consent when it is required by law to do so.

Minnesota Health Records Act: The Practice may disclose my dental information as follows:

1. For a Medical Emergency when the Practice is unable to obtain my consent due to a condition or the nature of the Medical Emergency;
2. To other health and dental care providers within Related Health Care Entities when necessary for my current treatment;
3. To a health care facility licensed by Minnesota Statutes chapter 144, Minnesota Statutes chapter 144A, or to the same types of health care facilities licensed by chapter 144 and chapter 144A that are licensed in another state under certain circumstances;
4. When the disclosure is specifically authorized by law;
5. When the disclosure is to the commissioner of health or the Health Data Institute under chapter 62J, provided that the commissioner encrypts the patient identifier upon receipt of the data; and
6. When the Practice is releasing a deceased's health care records to another provider for the purposes of diagnosing or treating the deceased patient's surviving adult child.

Consent and Authorization to Additional Limited Disclosures

By signing this form, I authorize the Practice to disclose my health information in the following limited ways:

Treatment: The Practice may release my information to another dentist, physician, or other health care professional to provide, coordinate, and manage my care and treatment.

Payment: The Practice may release my information so that it can bill me, my insurance, company, or another third-party for the treatment and services that I received. For example, the Practice may give my information to my dental plan so that it can pay the Practice or reimburse me for my treatment, or to obtain prior authorization from my dental plan to determine whether my plan will cover the treatment, or for purposes of an independent review of a denial of a claim.

Health Care Operations: The Practice may use and disclose my information to ensure that the Practice is properly operating, including, but not limited to, using my information to review the treatment and services that it provides, as well as evaluating the performance of its staff and dentists.

Business Associates: The Practice may disclose my information to Business Associates so that the Practice can perform the job that it has contracted them to do, such as marketing services. I understand that to protect the information that is disclosed, each business associate is required to sign an agreement requiring it to safeguard the information and not redisclose the information unless specifically permitted by law.

Appointment Reminders, Billing, and Other Communications: I authorize the Practice to send information regarding appointment and billing information via the following means:

- □ Mobile Phone Conformation
- □ Text message to my Mobile Phone
- □ Home Phone Confirmation
- □ Email Confirmation
- □ Work Phone Confirmation

Method of Sending Health Information: I authorize the Practice to send information regarding my health, treatments, and billing via the following means:

- □ Mobile Phone
- □ Text message to my Mobile Phone
- □ Home Phone
- □ Email
- □ Work Phone

If I have concerns with this Consent Form, I will discuss them with the Practice.

I understand that I may revoke this Consent at any time by providing written notice to the Practice, but that any actions already taken while my consent was in effect cannot be undone.

This consent will remain in effect unless and until I revoke my consent in writing

_____ _____

Patient/Guardian's Signature Date

_____

Patient's Name

_____

Guardian's Name