Sandra Makram, DDS

Certified, American Board of Pediatric Dentistry

13027 W. Linebaugh Ave Ste 102

Tampa, FL 33626

PATIENT HIPAA CONSENT

Patient(s) Name:_____Patient(s) DOB:_____

I _____, understand that by signing this Consent Form, I am giving my consent to Pediatric Dentistry of Westchase to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member or representative.

Name of Non-Parent:_____

Relationship:_____

Name of Non-Parent:_____

Relationship:_____

I understand that I have the right to revoke this consent at any time by giving written notice to Pediatric Dentistry of Westchase

Signature of Parent:_____

Please Print Name:_____

Date:_____