Consent Form

Prior to using or disclosing your protected health information to carry out treatment, payment or health care operations, the office of Dean T. Sueda, DDS MS Inc is required under federal law to obtain your consent. If you agree with its terms, please sign and date this consent below.

Should you desire a more complete description of the permissible uses and disclosures of your protected health information, you have the right to review a Notice of Privacy Practices (the "Notice") prior to signing this consent.

By signing this consent, you agree that we may use or disclose your protected health information to carry our treatment, payment or health care operations.

You have the right to request restrictions how your protected health information is used or disclosed to carry out treatment, payment or health operations. However, we are not required to agree to such restrictions. If we agree to a restriction that you request, such restriction will be binding.

You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.

I, _____ (name of parent/guardian/patient), hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent. I understand that this consent is between myself and the office of Dean T. Sueda, DDS MS. (with regards to my child _____). This consent form will be kept in the patient file and remain effect until written cancellation.

_____ _____

Signature of Parent/Guardian/Patient Date

_____

Print Name