Pediatric Dentistry Kahala
ALLEN K. HIRAI, D.D.S., LLC
4211 Waialae Avenue Suite #201
Honolulu, Hawaii 96816
Telephone (808) 737-0076

Patient Name:____

CONSENT FORM

Prior to using or disclosing your protected health information to carry out treatment, payment of health care operations, Dr. Hirai is required under federal law to obtain consent. Please review this consent. If you agree with its terms, please sign and date this consent below.

By signing this consent, you agree that we may use or disclose your protected health information to carry out 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 treatments, payment or health care operations. However, we are not required to agree to such restrictions.

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

I,____***(Patient/Guardian*)**,
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 Dr. Hirai and myself. No other individuals/organizations have permission to obtain confidential information under this consent.

This consent form will be kept in your patient file for a period of six (6) years.

Signature of Parent/Guardian:____**Date:**______________________

Print Name:____

FOR DENTIST USE ONLY:

SIGNATURE OF RECIPIENT:____**Date Received:**___________________

Acknowledgement of Receipt of Notice of Privacy Practices

I,____, parent/guardian for_____________________________________
Parent/Guardian **Patient**
have received a copy of this dental office's Notice of Privacy Practices.

Please Print Name:____

Signature:____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign.
Communication barrier prohibited obtaining acknowledgement.
An emergency situation prevented us from obtaining acknowledgement.
Other (please specify).____

Dental Office Signature:____**Date:**_________________