Keith M. Koga D.D.S.
98-211 Pali Momi St. Suite 725
Aiea, HI 96701
(808)484-0600

HIPAA CONSENT FORM

I have received and/or reviewed a copy of Keith Koga D.D.S. Notice of Privacy Practices

You may refuse to sign this acknowledgement.

Guarantor Signature: _____ Date: _____
(Parent or Legal Guardian ONLY, sign here)

Patient's Name: _____

I authorize the following individuals to act as appointed health care representatives with whom my child's health information may be discussed. I also authorize and give consent for the following individuals to bring my child to dental appointments and make treatment decisions on my behalf.

Provide name(s) below of anyone else besides Guarantor that may bring your child to dental appointments and make dental treatment decisions:

_____ _____
(Name) (Relationship to child)

_____ _____
(Name) (Relationship to child)

_____ _____
(Name) (Relationship to child)