

**ROBERT J. DEMBOSKI, D.D.S., INC.
525 N. CLEVELAND-MASSILLON ROAD, SUITE 105
SANCTUARY PROFESSIONAL BUILDING
AKRON, OH 44333-3332
330-666-6111**

HIPAA Consent, Permission to Treat, Photo Release, and Spousal Consent form

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notice at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I hereby agree to give Robert J. Demboski, DDS Inc permission to publish or to use in print or electronic media photographic images in which I may be included, in whole or in part for treatment planning, educational, promotional or advertising purposes and I waive the right to inspect and or approve the finished photographic product.

Dr. Demboski and his team have my permission to perform all treatment; preventative, cosmetic (by patient choice) and those deemed a dental necessity.

**Signature: _____ Date: _____
Patient, parent or legal guardian**

Spousal consent: I _____ give Robert Demboski, D.D.S., Inc. permission to share my existing dental work, future dental treatment needs and financial information with my spouse _____.