

QUASHA FAMILY DENTAL

PATIENT RECORDING CONSENT AI-ASSISTED CLINICAL DOCUMENTATION

Patient name: _____ Date of birth: _____

1. Purpose and scope

I consent to audio recording of my clinical conversations with Quasha Family Dental during consultations, examinations, and treatment visits for clinical documentation. Recordings may contain my voice, identifying information, health history, symptoms, diagnoses, and treatment discussions. This consent does not authorize video recording or photography.

2. AI-assisted notes and clinician review

The office uses an artificial intelligence (AI) documentation service to process audio, produce transcripts, and draft clinical notes. AI may make errors or omit information. My treating clinician will review and, as needed, correct the documentation before finalizing it in my dental record. AI does not replace my clinician or independently make treatment decisions.

3. Privacy, processing, and retention

Audio and related information may be transmitted to and processed by the office's documentation service provider and its authorized service providers for this purpose. The office must use applicable privacy and security safeguards and required business associate agreements. Access is limited to authorized persons for permitted purposes. Electronic processing carries a risk of unauthorized access despite safeguards. This consent does not authorize advertising, social media, sale of my recordings, or unrelated AI model training.

The office must complete and explain the following before I sign:

AI service/provider: _____

Audio/transcript retention and deletion policy: _____

Finalized clinical notes are retained as part of my dental record under applicable record-retention requirements. This form supplements the office's Notice of Privacy Practices; it does not waive my privacy rights.

4. Required office consent and withdrawal

Quasha Family Dental requires this signed consent as part of its routine clinical documentation policy before scheduled, non-emergency care. This is an office requirement, not a statement that the law requires patients to agree to recording. If I decline, the office manager will discuss how my care can proceed, including any available alternative arrangements, consistent with applicable patient-care obligations. Recording will not begin without consent.

I may ask questions or withdraw permission for future recording by telling the clinician or office manager verbally or in writing. Recording will stop when I withdraw permission. Withdrawal does not undo prior processing or require deletion of records that must be retained. The office will discuss arrangements for future care with me.

5. Acknowledgment and consent

I have read this form, received an explanation of the service and retention policy, and had my questions answered. I knowingly consent to audio recording and AI-assisted processing for the purposes described above. This consent applies to future clinical visits until I withdraw it or the office requests a new consent after a material change.

Patient / legal representative signature: _____ Date: _____

Representative printed name / relationship: _____

Staff witness: _____ Date: _____

Office use: Verify consent before recording. Obtain prior consent from all other participants, including companions, interpreters, and staff; this patient signature does not consent on their behalf.