Broken Arrow Family Dentistry

Consent to Use and Disclose Dental and Medical Information

Your signature on this form is an acknowledgement that you have received a copy of our Notice of Privacy Practices and gives your consent for our office to use and disclose the protected health information for the patient(s) listed below to carry out treatment, payment activities and healthcare operations.

- **Treatment:** includes activities performed by a dentist or other healthcare providers, as well as coordinating care with third parties, consultations involving dentists, physicians or other health care providers.
- **Payment:** includes activities involved in billing matters, determining eligibility for dental benefits, seeking payment for services we have provided, and obtaining pre-certification or pre-estimation for recommended treatment.
- **Health Care Operations:** includes associated business and administrative affairs of this office.

Notice of Privacy Practices: For further details regarding the possible use or disclosure of your information, we encourage you to read our Notice of Privacy Practices before you sign this consent form. We reserve the right to change our privacy practices and issue a revised Notice of Privacy Practices. You may request a current copy from our office at any time.

Right to Revoke: You have the right to revoke this consent at any time by giving us written notice. Please understand that revocation of this consent will not affect any action we took before we received your revocation, and we may decline to provide any further treatment after a revocation has been received.

Patient Names

Include yourself and any minors or adults for whom you have legal guardianship.
If you are signing for anyone other than yourself, please note your relationship to that patient.

_____ _____ _____

_____ _____ _____

_____ _____ _____

I authorize Broken Arrow Family Dentistry to use and disclose the dental, medical and health information for myself and the minors listed herein.

Date: _____ Signature: _____

Insurance Authorized Signature Form

I, the undersigned, expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered, or to be rendered, without obtaining my signature on each and every claim to be submitted for me and/or my dependents; and, that I will be bound by this signature as though I, the undersigned, had personally signed the particular form.

I understand that I am responsible for all costs of dental treatment and authorize payment directly to my dentist for all insurance benefits otherwise payable to me.

_____ _____

Date **Authorized Signature of Covered Employee**

_____

Please Print Name