HIPAA DISCLOSURE

I understand that this office submits my insurance claims by telephone, mail and computer. Information regarding my treatment plan, including but not limited to exam information, surgery recommended and/or performed, and x-rays may be sent for treatment, payment, or healthcare operations.

At any time I may review this office's privacy policy. To review this material please ask any of the office staff.

At any time the patient may request that this information be withheld. This request must be in writing, and may delay or negate the possibility of treatment and or insurance authorization.

I authorize this office to send information regarding my treatment plan, including but not limited to, exam information, surgery recommended and/or performed, and x-rays to my general dentist, physician, or insurance company.

Print Name: _____

Signature: _____
Responsible Party/ Guardian

Date: _____

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