DAKOTA DENTAL
AND WELLNESS CENTER
A Different Kind of Dentistry

Consent for Use and Disclosure of Health Information

Name: _____DOB: _____

Address: _____

Phone: _____ Email: _____

By signing below, I acknowledge the information I have provided on this form and other registration forms is true and correct to the best of my knowledge.

I consent to the use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I consent to have diagnostic records taken at exams, which include, but are not limited to, digital photos, scan and x-rays.

I authorize my insurance company to remit payment to my dentist for services rendered. I agree that my dental records for treatment may be released to my insurance company for claims processing. I authorize the release and disclosure of any and all dental records to my physician, as said physician may request.

I have the right to read the notice of Privacy Practices before deciding whether to sign this Consent. The Privacy Notice provides a description of treatment, payment activities, and healthcare operations, of the uses and disclosure we made of your protected health information, and of other important matters about protected health information.

If presenting a minor for treatment, I acknowledge by signing below, that I have the legal authority to consent to treatment of said minor. I also agree that I am responsible for any balance not paid by insurance, regardless for custody status.

I have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action taken in reliance of the Consent before Dakota Dental received the revocation, and that Dakota Dental may decline to treat me if I revoke this Consent.

Signature _____Date _____

Printed Name _____

Photograph Release: I hereby give Dakota Dental and Wellness Center permission to copyright photographs taken of me, in the name of Dakota Dental and Wellness Center, and to allow them to publish photographs, in whole or in part, in patient educational materials, advertising, website or social media. I understand that in no instance will I be identified by name.

Signature _____ Date _____

Printed Name _____

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