NORTH BENTON DENTAL CARE

Patient Consent Form for Use of Disclosure of Patient's Protected Health Information

This form must be completed by the individual, whose protected health information is to be disclosed, by a parent or guardian if the person is a minor under state law.

- I hereby authorize North Benton Dental Care to release the following personal health information for: Dental services claims information, prescription, diagnostic, treatment, and/or care management services, reviews required by HHS or HIPAA-compliant health care operations.
- I understand that consent may be revoked by myself or North Benton Dental Care at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.
- I understand that when appropriate, credit bureau reports may be obtained.
- I authorize payment of dental benefits to North Benton Dental Care.
- I authorize North Benton Dental Care to release any written, verbal, or radiographic dental information for requested dental reports and/or insurance processing.

The above information may be released to:

Friend/Relative _____

Name of Patient _____ Date: _____

Signature: _____
Patient/Responsible party(if Minor)/Personal Representative)