Consent to Use or Disclose Dental and Medical Information

I._____, acknowledge that I have received a copy of the Notice of the Privacy Practices of the office of Northshore Metropolitan Dental Associates.

I understand that the office may charge me **$35.00** should I fail to keep my appointment or fail to provide the office with 24 hours advance notification of cancellation.

I authorize Northshore Metropolitan Dental Associates to use and disclose my dental, medical. and health information for the following purposes:

- Treatment-includes activities performed by a dentist or dental hygienist. as well as coordinating or managing care provided to you with third parties, and consultations involving dentists. physicians. and other health care providers.
- Payment-includes activities involved in determining whether you are eligible for dental plan coverage. billing matters. and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of chargers. precertification and preauthorization of services.
- Health Care Operations-includes associated business and administrative affairs of this office

OPTING OUT:

☐ I do not wish my protected health care information to be released to the following persons

_____

☐ Add other opting out provisions as reflected in YOUR HIPAA Privacy Notice.

Please print your name: _____

Please sign: _____

Date: _____

_____

☐ I decline to sign the Consent

OFFICE USE:

The office was unable to obtain a signed consent form from the above patient for the following reasons: