

Consent For Care and Release of Information

GENERAL CONSENT TO CARE

I understand that my condition requires dental care. I voluntarily consent to services provided by Pierpan Dentistry.

RELEASE OF INFORMATION FOR PAYMENT OF ACCOUNT

I agree that Pierpan Dentistry and its physicians/dentists participating in my treatment may release to my insurers, other payers or other persons as necessary, any information which may be needed for the purpose of billing, collections or payment of claims for services provided.

RELEASE OF INFORMATION TO OTHER HEALTHCARE PROVIDERS

I agree that Pierpan Dentistry and its physicians/dentists participating in my treatment may release my medical information to other healthcare providers or health care facilities that have referred me to for additional treatment. The information released will be pertinent to the diagnosis/condition for which I have been referred.

ACCESS TO HEALTHCARE RECORDS

In addition to yourself, please list the **name and relationship** of other person (s) with whom we can share your medical/dental information with if requested;

1. _____
2. _____
3. _____

Signature _____ Date _____