GHAREEB DENTAL GROUP

ghareebdentalgroup.com

POCA	SOUTH CHARLESTON	CROSS LANES	ST. ALBANS	TEAYS VALLEY	KANAWHA CITY
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PATIENT CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing. Revocation of this consent is only applicable from date of revocation forwards and cannot be applied to past information used or disclosed.

I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me.

I certify that all answers on my health history and patient registration information have been answered accurately to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my health.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care:

Name(s): _____

Patient Print _____ Signature _____ Date _____

If patient is a minor, Parent/Guardian Print _____ Signature _____