CONSENT TO DISCLOSE

PRIVATE HEALTHCARE INFORMATION

FOR TREATMENT, PAYMENT, AND/ OR HEALTHCARE OPERATIONS

I, _____, Social Security Number _____, Date of birth _____, herby authorize and consent for MONROE DENTAL CLINIC, to release any and all medical, dental, and / or psychological reports or records, including, but not limited to, medical/ dental notes, physician narratives, office notes, operative notes, discharge summaries, doctor's/ dentists orders, nurses notes, lab reports, test results, physical therapy progress notes, patient progress reports diagnosis, post –operative reports, post- operative diagnosis, pathology reports, X-rays, MRI'S, any records reflecting treatments for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse, including any x-rays, diagnostic studies, laboratory slides, clinical abstract, histories, charts and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding my medical/ dental care as necessary to carry out treatment, obtain payment, and / or conduct other healthcare operations.

I understand that the operations of this office of MONROE DENTAL CLINIC is being visually and orally recorded by a virtual private network. I hereby authorize and consent to such recording.

The release of the matters listed above is being authorized for purposes of obtaining medical/ dental treatment, payment for such service and other health care operations.

A copy of this authorization is agreed by the undersigned to have the same effect and force as an original.

Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I further understand that I have the right to review MONROE DENTAL CLINIC'S privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

Signed this _____day of _____, 20_____

_____

Signature

_____

Printed name

_____

Parent/ legal guardian of patient(print)

Special Restrictions:

_____

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