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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name_____

Patient number _____

Patient address _____

Patient phone number _____

I authorize the professional office of my dentist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:

2. To whom may the information be released [name(s) or class(es) of recipients]:

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):

4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

[For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.]

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____Print Name_____

Source of Authority_____

CHEN DENTAL HEALTH

Patient Consent

1. I do authorize and give consent to CDH, the dentist and his/her staff to administer treatment, including but not limited to local anesthesia and other such treatment, which, in their judgment, may be necessary for the prudent exercise of dental care. I understand that the use of medications, anesthetics and some procedures embody a certain risk.

2. I acknowledge that no guarantee or assurance has been given by anyone to the result that may be obtained.

3. I understand that during the procedure(s) unforeseen conditions may arise that necessitate different procedures from those planned. I consent to the performance of additional procedures that are deemed necessary in the professional judgment the dentist and I understand that payment for those procedures is my responsibility.

4. I consent to disposal of any tissues or body parts that may be removed.

5. I attached medical and dental history was completed fully and accurately to the best of my knowledge.

6. I understand and agree on supplying copy of payment type if service(s) rendered is not paid in full **Please initial here .** I agree that signing treatment confirms that I agree to payment plan agreed upon.

7. I understand responsibility for payment of dental services provided in this office for myself or my dependent is mine. unless other arrangements are made prior to treatment, accounts are to be paid on the day services are provided. I have read and I understand Chen Dental Health financial policy.

8. I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Chen Dental Health. In the event of legal acction of this account, I agree to pay any and all cost of such suit, collection and attorney fees. I have reviewed the treatment plan and authorize the release of any information relative to this claim.

9. A service charge of 1.5% per month (18 % per annum) will be added to the unpaid balance of all accounts not paid in full within 90 days of treatment or my account.

10. I grant my permission to you or your assignees to telephone me at home or at my work to discuss matters related to this consent, my treatment or my account.

11. I have had the opportunity to review Chen Dental Health's Notice of Privacy Practices.

12. I understand that if I am unable to keep my appointment, i need to let CDH know at least 24 hours in advance. **I also understand Chen Dental Health reserves the right to assess a minimum $40 fee for late cancellations and/or missed appointments.**

Patients Name(Print)	Date
Signature of Patient or Responsible Party	Relationship (if responsible party)