Presser Dental Group
FERNANDO PRESSER DMD.
LOUIS F. ROSE, DDS, MD
D. WALTER COHEN, DDS

Periodontics, Advanced Restorative and Implant Dentistry

2020 LAND TITLE BUILDING
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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
CONSENT FOR USE AND DISCLOSURE OF DENTAL AND MEDICAL INFORMATION

Purpose of Consent: By signing this form you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. The activities may be carried out by telephone, US mail or email. The notice takes effect 9/1/2017 and will remain in effect until unless notified otherwise.

I authorize Drs. **Presser, Rose and Cohen** to use and disclose the dental, medical and health information of

_____for the following purpose(s);
(Patient or guardian name)

- **Treatment-** includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to you with third parties (i.e. your insurance carrier), consultations involving other dentists, physicians, laboratories and other health care providers.

- **Payment-** we may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management and determinations of eligibility and coverage to obtain payment from you, an insurance company or another third party.

- **Health Care Operation –** includes associated business and administrative affairs of this office which include but are not limited to direct patient communication for purposes of appointment scheduling and confirmation.

You have the right to revoke this Consent. However you must revoke this consent in writing. Any revocation would not pertain to information already used or disclosed pursuant to this Consent during the time frame within which this consent is effective.

I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

_____ _____
Date **Signature of Patient**

_____ _____ _____
Date **Signature of Personal Representative** **Relationship to patient**

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.