University Oral Surgery Center
Ramin Shabtaie, DDS, Inc
Consent Form for Use or Disclosure of Patient Health Information

Patient's Name:_____

You may request a copy of this completed form. If you have questions, ask to speak with the our staff.

I authorize the use or disclosure of the health information of the above named patient for the purpose of providing treatment, collection of payment, communication with other healthcare professionals, caregivers, parents, relatives or other individuals authorized below:

_____

and any related activities as permitted and required by law. I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be canceled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan or eligibility for benefits. I understand I may have a copy of this authorization.

The health information to be used or disclosed may include information provided by patient/guardian or caregiver, other healthcare providers and insurance companies, otherwise is limited to the following: *(you may note dates, procedures or use other description)*

_____

_____

This authorization is valid until treatment is finalized or at collection of all fees, whichever occurs last, or otherwise indicated below:

_____

Signature: _____Date:_____

Print name: _____

Signed by: ☐ Patient ☐ Parent/legal guardian

☐ Personal representative of the patient — *describe the legal authority that permits the representation:* _____