Attention All Patients: The US Government Requires The Use Of This Form

CONSENT TO USE OR DISCLOSE DENTAL AND MEDICAL INFORMATION

I authorize Dr. Robert C. Kuepper to use and disclose the dental, medical and health information of:

_____

(Patient's name- please fill in above) for the following purpose(s):

Treatment-includes activities performed by a dentist, as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians and other health care providers.

Payment-includes activities involved in determining whether you are eligible for dental plan coverage, billing matters and reimbursement for your dental benefit claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, precertification and preauthorization of services.

Health Care Operations – includes associated business and administrative affairs of this office.

Other (explain): _____

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.

_____ _____

Date Signature of Patient

_____ _____

Date Signature of guardian or person authorized by law

Rev. 03/10