Gannett Drive Dental

Dr. John A. Kivus, DMD

Dr. Jacob Fillebrown, DMD

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations, such as quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health informed is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
(Patient, parent or legal guardian)

If signed by other than patient, state relationship to patient: _____

IF YOU HAVE DENTAL INSURANCE, PLEASE READ AND SIGN BELOW.

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with (fill in insurance company name) _____ and sign directly to Dr. John A. Kivus or Dr. Jacob Fillebrown all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges (whether or not) paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature: _____ Date: _____