HUDSON HEADWATERS
ALBERT R. TUCKER DENTAL CENTER

☐ Patient or Patient Representative refused to sign/complete this document.

RELEASE OF DENTAL INFORMATION AND ASSIGNMENT OF BENEFITS

I understand that my health information may be used or disclosed for the purposes of treatment, payment, and operations in accordance with state and federal regulations for privacy and security. I understand that this may include disclosures of information to my insurance carrier(s), including Medicare, private insurance, and any other dental/health plan, to issue payment directly to the Network for services rendered to myself and/or my dependents. I am responsible for understanding the limitations of my insurance coverage and to present any co-pay, co- insurance, deductible or other personal obligations at the time service is rendered. I acknowledge that any expenses not covered under an insurance policy will be my responsibility. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Additionally, I give the Network permission to disclose to a relative or friend my location and general condition, or other information directly relevant to that person's involvement in my care[1], to those I have named below:

_____ _____
(First and last name) *(Relationship to patient)*

_____ _____
(First and last name) *(Relationship to patient)*

_____ _____
(First and last name) *(Relationship to patient)*

Please note: this document **does not expire** and is considered to be in effect unless the patient/personal representative updates or revokes it in writing. Furthermore, this document only applies to dental-related information and does not include the release of medical information.

_____ _____ _____
Signature of Patient or Representative Authorized by Law | Print Name | Date