CONSENT

PERMISSION TO COLLECT, USE AND DISCLOSE PERSONAL INFORMATION

Patient Name	Test Patient

Our office understands the importance of your personal information. We will collect and use your personal information in the form of Contact Information; Medical/Dental History; & Financial Information for these appropriate purposes:

- To diagnose and provide safe and efficient health care
- To assess your oral health and advise you of your treatment options
- To communicate with you and your other health care providers
- For scheduling appointments, billing purposes, including dental insurance forms
- For teaching and demonstration, on an anonymous basis
- To comply with the College of Denturists, Provincial and Federal regulations and to generally comply with the law
- To comply with the audits and evaluations of the dental practice
- To provide invoices, process credit payments and collect unpaid accounts
- To permit potential purchases or their agents to evaluate and audit the practice in preparation for a potential sale of the practice

Contact information is/may be disclosed to a third party health benefit provider or insurance company when submitting a claim on the patients' behalf, for payment or reimbursement of all or part of the cost of the treatment provided, or when a patient has requested a preauthorization of a proposed treatment.

By signing this Consent Form you agree that you have provided your personal information. You consent to the collection, use and disclosure of the information for the appropriate purposes listed above. Your information may be accessed by the College of Denturists or other regulatory authorities acting under statute of a legal issue. We will seek your approval, in advance, if a new purpose should arise for the use and/or disclosure. You may withdraw your consent for the use and disclosure of your personal information at any time. We will explain the process and the ramifications of your decision to do so.

✔ I authorize release to my benefits plan administrator information contained in claims submitted electronically. I also authorize the communication of information related to the coverage of services described to the named denturist. This authorization shall continue in effect until the undersigned revokes the same.

Patient Signature