Kierland Dental Center

Michael R. Thompson, D.D.S, PC

Consent for Release of Information:

I understand that, under the Health Insurance Portability & Privacy Act of 1996 (HIPPA), that I have certain rights to privacy in regards to my protected health information. I authorize Michael R. Thompson, D.D.S, PC to release this information to: conduct normal healthcare operations, obtain payment from third-party payers, and plan my treatment and follow up with our healthcare providers.

Receipt of Privacy Policies and Practices:

I have received and copy of Michael R. Thompson, D.D.S., PC's Privacy Policies and Practices and reviewed them prior to giving consent for release of information and treatment. I understand that I may request in writing to restrict how my private information is disclosed to carry out treatment or for payment by a third-party payer.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Patient's Name and Date of Birth Date

Legal Representative Information (if applicable):

Name:_____ Relationship:_____

Address:_____

Street City State Zip

Phone:_____ Email:_____