ROUND ROCK ORAL SURGERY
Ryan Weber DDS, MD
7200 WYOMING SPRINGS #1000
ROUND ROCK, TEXAS 78681

CONSENT TO USE AND DISCLOSURE OF HEALTH/DENTAL INFORMATION FOR TREATMENT

Name____

Social Security #______________________________Birthdate_____________________________

I understand that as part of my healthcare, this organization originates and maintains health/dental records describing my health/dental history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing competence of healthcare professionals.

I understand I have the right:

- To object to the use of my information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations, and that the organization is not required to agree to restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health/dental information:

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If you would like to give permission to a family member/designated individual to have access to your medical records, make appointments, or receive medical or financial information regarding your account please list names below:

Print Name/Relationship____

Print Name/Relationship____

I, the undersigned, certify that I have insurance coverage with ___________________________________
and assign directly to the physician listed above, any and all benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by the insurance. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment. (Section 112B of the Social Security Act and 31 U.S.C. 3801-3812)

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Patient Signature (if minor, guardian signature) Date