AUTHORIZATION AND CONSENT

General Consent to Treatment

I agree and consent to a dental examination. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to being done. Also, I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information

I authorize Redmond Dental Group to release information regarding my dental/medical history, diagnosis or treatment to third party payors and/or other health professionals.

Assignment of Insurance Benefits

I authorize and request my insurance company to pay my benefits directly to Redmond Dental Group.
I understand and agree to the **General Consent to Treatment.**
I authorize the **Release of Information.**

X____ Date____________________
Signature of patient, parent or Guardian

NOTICE OF PRIVACY FOR PROTECTED HUMAN INFORMATION

I hereby acknowledge that I I have received a copy of this practice's Notice of Privacy Practices.
I understand that I may ask any questions I may have regarding this notice.

Signature____ Date____________________