Authorization and consent for services

Authorization for your information to be given to a spouse/family/person paying for your account. Or anyone else you choose:

I authorize and give permission to William G Harper, DDS PC, to allow the following persons to have knowledge of my account and perform any acts that are necessary and may affect my dental health. This includes any appointments/scheduling, treatment information, picking up Rx as needed, or discussion of financial records. I understand that if I want to revoke this right, I must provide it in writing. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

The following person(s) may receive my patient information:

Name: ___________________________________ Relationship:______________________________

Name: ___________________________________ Relationship:______________________________

Signature:_________________________________ Date:________________

Team Member Signature:____

Consent for services

1. I hereby authorize doctor or staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and the employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital on any possible complication.
4. I hereby give Dr. Harper the absolute right and permission to use my photographs/slides for education or promotional purposes. The undersigned completely and forever releases any right to present or future compensation in connection with the use of said photographs/slides. I understand that to revoke this right, I must provide it in writing.

Signature:____

Date:________________