MILFORD PEDIATRIC DENTISTRY, INC
Consent Form – Parent / Guardian

Patient Name (print): _____ **Date of Birth:** _____

Consent of Disclosure of Protected Health Information, Billing, and/or Medical/Dental Information:

1. I hereby consent for Milford Pediatric Dentistry to use and disclose personal protected health information ("PHI") on the voicemail systems at the following phone number(s):

#1 _____ #2 _____ email:_____

2. Return Messages (please check one):

❑ I hereby consent for Milford Pediatric Dentistry to leave a detailed message with a person, other than myself, indicating that a representative has called and that a return call is needed. They may leave a message with:

Name:_____ #_____

Name:_____ #_____

❑ I do not consent for Milford Pediatric Dentistry to disclose any "PHI" on any telephone or voicemail message system.

3. Billing Information:

I hereby consent for Milford Pediatric Dentistry to discuss this patient's billing & payment information with the following person(s):

Name: _____ Relationship to patient: _____ # _____

Name: _____ Relationship to patient: _____ # _____

4. Medical / Dental information via telephone or in person:

I hereby consent for Milford Pediatric Dentistry to discuss this patient's medical/dental information with the following person(s):

Name: _____ Relationship to patient: _____ # _____

Name: _____ Relationship to patient: _____ # _____

_____ _____
Parent / Guardian Signature Date

This consent will remain in effect until revoked by me in writing.

Assignment of Benefits:

I hereby assign all dental benefits to which I am entitled including private insurance to Milford Pediatric Dentistry, Inc. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by my insurance. I herby authorize assignee to release all information necessary to secure payment.

_____ _____
Parent / Guardian Signature Date