Consent for Purposes of Treatment, Payment, & Healthcare

I consent to the use or disclosure of my protected health information by Springfield Dental Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or conduct healthcare operations of Springfield Dental Group. I understand that diagnosis or treatment of me by David G. Scurria, DDS and Matthew W. Scurria, DDS may be continued upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Springfield Dental Group is not required to agree to the restrictions that I may request. However, if Springfield Dental Group agrees to a restriction that I request, the restriction is binding on Springfield Dental Group, David G. Scurria, DDS and Matthew W. Scurria, DDS.

I have the right to revoke this consent, in writing, at any time, except to the extent that David Scurria, Matthew Scurria or Springfield Dental Group has taken action in reliance on this consent.

Signature of Patient, Parent, or Representative

Name of Patient

Date