

THOMAS S. TURRY, D.D.S., PA

CONSENT AND AUTHORIZATION OF RELEASE OF INFORMATION

1. Release of Information: I consent to the release and use by Thomas S. Turry's office of dental and other information about me to the extent permitted by law to the following:
 - The health care provider being advised or consulted in connection with my treatment and care;
 - To a health plan, insurer, third party payer, third party administrator or other organization providing me with health benefits, for the purposes of claims payment and benefit determinations, fraud investigation, or quality of care studies and reviews;
 - To a person or organization in connections with Thomas S. Turry's office health care operations. These operations may include interdisciplinary care conferences, quality improvement activities, performance evaluations, business management, and other related activities.
2. Revocation: I understand that this consent shall continue until I revoke it, which I may do at any time by giving written notice to Thomas S. Turry's office.

NOTICE OF PRIVACY PRACTICES

1. Confidentiality. It is the policy of Thomas S. Turry's office to protect the privacy and confidentiality of patients' dental information.
2. Notice of Privacy Practice. Attached is the Notice of Privacy Practices which explains how Thomas S. Turry's office may use and disclose my dental information. It also explains my rights regarding this kind of information.
3. Acknowledge of Receipt. I acknowledge that I have received the Notice of Privacy Practices.

Patient's Name

Date of Birth

Signature of Patient (if applicable)

Date

Signature of Legal Guardian (if applicable)

Date