David R. Deitrick D.D.S., P.A.

Family Dentistry

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents including finance charges for any unpaid account over 90 days past due, any fees charged by a collection agency, any attorney's fees and/or any other related charges.

I certify that I have read the above paragraph and understand the information to the best of my knowledge.

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Signature of patient or parent, if minor ***Date***

I have been given the ***Notice of Privacy Practices (HIPAA)*** *that describes how my health information may be disclosed and how I can obtain access to this information.*

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Please Initial