Consent for Purposes of Treatment, Payment, & Healthcare

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

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

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

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Signature of Patient, Parent, or Representative

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Name of Patient

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Date