



**SCHNEIDER & COCO**  
FAMILY DENTISTRY

## Consent to Use or Disclose Dental / Medical Information

By signing, I authorize Schneider & Coco Family Dentistry to use and/or disclose certain protected health information of

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Patient Name

I understand that I have certain rights to privacy regarding my protected health information, which are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

The information will be used or disclosed for the following purpose:

- Treatment: includes activities performed by a dentist or dental hygienist, as well as coordinating or managing care provided to you with third parties, and consultations involving dentists, physicians, and other health care providers
- Payment: includes activities involved in determining whether you are eligible for dental plan coverage, billing matters and reimbursement for your dental claims, as well as utilization management programs addressing review of dental services for clinical necessity, appropriateness of charges, precertification and preauthorization of services
- Health care operations: includes associated business and administrative affairs of the office.

I understand that I have the right to request specific restrictions as to how my protected health information is used and disclosed for the above listed purposes.

I understand that I have the right to revoke this consent at any time. Revocation must be received by Schneider & Coco Family Dentistry in writing. Any revocation would not pertain to any information already used or disclosed pursuant to this consent during the time frame within which this consent is effective.

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Date

Signature of Patient

-or-

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Date

Signature of guardian or other person authorized by law

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Relationship to Patient