JOE W. POTTER, D.D.S., P.A.
BRANDON K. FLORENCE, D.D.S.
207 W. Belt Line Rd.
Cedar Hill, TX 75104

Consent for Insurance Release

We are committed to protecting your confidentiality and right to privacy. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain consent from you prior to releasing any information to your insurance agency. If you desire for us to prepare your insurance claim and ready it for mailing for you, we need your consent. This will also permit us to respond to requests by your insurance company for explanation of treatment necessity or radiograph duplication and forwarding. Both are common requests by insurance companies necessary to complete claim processing and reimbursement.

Please understand this in no way allows for us to release any information regarding you or your treatment to any contractors, employers, government agencies, or any other third parties, except when stipulated by law. This is a strict statement regarding provision of information to your insurance company for processing your claim for reimbursement.

_____ _____

Patient Signature **Date**

Insurance Information

Primary Insurance _____

Address _____

City _____ State _____ Zip ____

Phone # _____

Insured Name _____

Insured SSN _____

Insured DOB _____ Insured ID# _____

Employer _____

Insured's Relationship to Patient _____

If patient is over 18, is patient a student? _____

If so, where? _____

Secondary Insurance _____

Address _____

City _____ State _____ Zip _____

Phone # _____

Insured Name _____

Insured SSN _____

Insured DOB _____ Insured ID# _____

Employer _____

Insured's Relationship to Patient _____

If patient is over 18, is patient a student? _____

If so, where? _____