The Hill Dental Group, PLLC
8338 Spring Cypress Road
Spring, TX 77379

Patient Name: _____ Date:_____

Authorization and Consent to Release Information and Payment

I, _____, authorize The Hill Dental Group, PLLC to release any information including, but not limited to: records of examination, diagnosis and treatment rendered, to third-party payers and/or health care practitioners, dental professionals and labs in order to provide continuity of care.

I authorize and request my insurance to pay directly to The Hill Dental Group, PLLC, insurance benefits otherwise payable to me.

I understand that The Hill Dental Group, PLLC is a private, fee for service practice and is not constrained by the limitation of insurance policies in determining what is best for me. In some instances, my dental insurance carrier may not pay any or just a portion of the fee for my out-of-network services. I agree to be responsible for payment of **all** services rendered on the above named patient that is not covered or disallowed by my insurance company.

I consent to the making of photographs, videotape, x-rays, and/or models, from time to time, and to the use of these for purpose of scientific papers and/or demonstrations.

I consent to being contacted for appointments or account information using the email address given on the Patient Information Form.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling 281-276-0911.

_____ _____

Patient or Legal Guardian Signature Date