Ian M. Bever, D.D.S.
Bever Family Dentistry

Patient Authorization Form

I understand that I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (insurance company)
- The day to day healthcare operations of your practice.

I also authorize disclosure to the following persons:

_____

_____

_____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent, is not affected.

Patient name (Print): _____

Signature: _____

Today's Date: _____

Ian M. Bever, D.D.S.