Cascade Periodontics
David M. Lamberts, D.D.S., P.C.

Signature Authorization & Confidentiality Form

Patient's name: _____ Date of birth: _____ Date: _____

Release of Information

I authorize the release of any medical information necessary (including, but not limited to any and all information regarding serious communicable diseases and infections as defined by statute and the Michigan Department of Public Health, (i.e., VD, TB, Hepatitis B, HIV, AIDS, and ARC), or any alcohol or drug abuse information, etc.): 1) to process claims (information released hereunder may be provided to any independent auditors hired or retained by any and all third party payers, private health insurers or any employer for any purpose for the purpose of enabling these independent auditors to analyse charges made for services rendered to the patient; this authorization includes authority to fax such information, if necessary; moreover, any information released hereunder may be released or communicated verbally, in writing, or through electronic communication including telephone, mail, fax, email, etc.) 2) to be referred to a specialist for dental care, 3) to obtain services for lab, x-ray, and other diagnostic services.

Responsibility of Payment

I authorize and accept responsibility for payment of any fee.

_____ _____ _____
Signature Date Relationship

Responsibility of Patient

I am willing to take responsibility for my own health in such matters as weight, diet, smoking, exercise, alcohol and drug use and in following my doctor's instructions. I understand that abuse in any of these areas may adversely affect my health and treatment.

I have read and understand all of the above and agree to the terms set forth by David M. Lamberts, D.D.S., P.C.

This release shall be effective only as long as is necessary to accomplish the purpose for which it is given or until it is specifically revoked in writing by the undersigned.

_____ _____ _____
Signature Date Relationship

Contact Instructions

❍ Yes I authorize David M. Lamberts, D.D.S., P.C. and staff to leave information at the designated phone number and/or email address (below) regarding my care including, but not limited to, scheduled appointments, lab and x-ray results. Results may be given to the individuals answering the phone or left on the message machine.

❍ No I do not authorize David M. Lamberts, D.D.S., P.C. and staff to leave information regarding my care or scheduled appointments on a message machine or given to any person except myself.

I authorize David M. Lamberts, D.D.S., P.C. and staff to communicate any and all aspects of my dental care, including but not limited to financial information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I can be contacted at: Phone #: _____ Email: _____