Michael A. Liska, DDS

GENERAL CONSENT AND DISCLOSURE
HIPAA COMPLIANCE

General Consent: I give permission to Michael A. Liska, DDS and its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments and/or examinations, conduct laboratory or other tests, give injections, medication and other treatment(s) and render other health services to the patient identified on this form.

Authorization for Release of Information: I hereby authorize Michael A. Liska, DDS to furnish such professional information, as may be necessary for the completion of my claims by the health insurance carriers, from the medical records complied during my present visit and hereby release the said facility from all legal liability that may arise from the information requested.

Authorization of Insurance Benefits: In consideration of services rendered, I hereby irrevocably assign and transfer to Michael A. Liska, DDS all rights, title and interest all benefits payable to me for my services described herein as provided in the mentioned policy and policies of insurance. I agree to pay Michael A. Liska, DDS the charges which exceed the amount paid by the named insurance company.

Questions: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I may have about the services have been answered to my satisfaction.

HIPAA COMPLIANCE/NOTICE OF PRIVACY
We are required by law to maintain the privacy of/and provide individuals with notice of our legal duties and privacy practices with respect to protect all health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

_____
Patient Name

_____
Person Authorized to Consent (if Not Patient)

_____
Signature

_____
Date