*Westpark Dental*
6400 Westpark, Suite 430, Houston, TX 77057
Office 713-977-6917, Fax 713-534-1354

## Consent to Disclose
## Private Healthcare Information
## For Treatment, Payment and/or Healthcare Operations

I _____ DOB: _____ SSN: _____
Print Patient's Name

Hereby authorize and consent for WESTPARK DENTAL to release any and all dental/medical reports or records, including, but not limited to progress notes, x-rays diagnostic, treatment, financial, insurance and personal demographic **to conduct healthcare operations only.**

The release of the matters listed above is being authorized ***for purpose of obtaining dental treatment, payment of such services and other healthcare operations.*** A copy of this authorization is agreed by the under signed to have the same effect and force as the Original. Any person, firm or entity that released matters pursuant to this authorization is hereby released from any liability that might otherwise result from the release of those matters. I further understand that I have the right to review WESTPARK DENTAL privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should choose to do so.

Print Patient's Name: _____

Print Parent/Guardian Name: _____
(If above patient is a minor)

**Signature of Patient/Guardian**: _____

Date: _____

Special Restrictions: _____

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