

**BRANDON K. FLORENCE, D.D.S.**  
**207 W. Belt Line Rd.**  
**Cedar Hill, TX 75104**

## **Consent for Insurance Release**

We are committed to protecting your confidentiality and right to privacy. In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we are required to obtain consent from you prior to releasing any information to your insurance agency. If you desire for us to prepare your insurance claim and ready it for mailing for you, we need your consent. This will also permit us to respond to requests by your insurance company for explanation of treatment necessity or radiograph duplication and forwarding. Both are common requests by insurance companies necessary to complete claim processing and reimbursement.

Please understand this in no way allows for us to release any information regarding you or your treatment to any contractors, employers, government agencies, or any other third parties, except when stipulated by law. This is a strict statement regarding provision of information to your insurance company for processing your claim for reimbursement.

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**Patient Signature Date**

## **Insurance Information**

Primary Insurance \_\_\_\_\_

Primary Insurance \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_

Phone # \_\_\_\_\_

Insured Name \_\_\_\_\_

Insured Name \_\_\_\_\_

Insured SSN \_\_\_\_\_

Insured SSN \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured ID# \_\_\_\_\_

Insured DOB \_\_\_\_\_ Insured ID# \_\_\_\_\_

Employer \_\_\_\_\_

Employer \_\_\_\_\_

Insured's Relationship to Patient \_\_\_\_\_

Insured's Relationship to Patient \_\_\_\_\_

If patient is over 18, is patient a student? \_\_\_\_\_

If patient is over 18, is patient a student? \_\_\_\_\_

If so, where? \_\_\_\_\_

If so, where? \_\_\_\_\_