

**AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION TO  
AGENT (S) UNDER HIPAA AND CALIFORNIA LAW**

I, \_\_\_\_\_ at \_\_\_\_\_, grant to

The Dental Trauma Center at 12243 South Hawthorne Blvd, Hawthorne, CA 90250

the authority to receive information and all medical records, reports, and x-rays regarding my health care needs.

This release shall apply to any of my information which is governed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC § 1320d and 45 CFR pts 160, 164, and California law. I intend my agent to be dealt with by all my health care providers, as required by HIPAA and California law, in the exact same way as I would be treated with respect to my rights regarding the use and disclosure of my identifiable protected health information or other medical records.

Pursuant to HIPAA and California law, I authorize any covered entity, including, but not limited to the entity named above, as well as, any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or any other covered health care provider, any insurance company, and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking to be paid for services, to give, disclose, and release to my agent and successor agent(s), named above, without restriction, inclusive of means of electronic submission and dissemination (i.e. email, fax, etc.), and at the request of my agent and successor agent(s), all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition.

I understand that I may revoke this authorization at any time by written notice to the covered entity.

This authorization shall expire on the date of my death unless validly revoked prior to that date.

Under California law, all recipients of protected health care information may not redisclose it except as required or permitted by law.

Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA regulations, inclusive of redisclosure by means of electronic submission and dissemination,

This authority shall supersede any prior agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information.

I have been made aware of and have had an opportunity to read this office's Privacy Practices and understand its terms. I also acknowledge that I may request a copy of said Privacy Practices at any time by written notice to the covered entity.

I have a right to a copy of this authorization.

Date: \_\_\_\_\_/\_\_\_\_\_/2026

\_\_\_\_\_  
Principal name (Printed)

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Interpreter

# THE DENTAL TRAUMA CENTER

## **E - MAIL CONSENT FORM**

Patient name: \_\_\_\_\_

Practice Physician: \_\_\_\_\_

### **1. RISK OF USING E-MAIL**

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

- a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. Schames and the Practice are not encrypted, so E-mails may not be secure. Therefore it is possible that the confidentiality of such communications may be breached by a third party.**
- b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- c) E-mail senders can easily misaddress an E-mail.
- d) E-mail is easier to falsify than handwritten or signed documents.
- e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
- f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
- g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
- h) E-mail can be used to introduce viruses into computer systems.  
Practice server could go down and E-mail would not be received until the server is back on-line.
- i) E-mail can be used as evidence in court.

### **2. CONDITIONS FOR THE USE OF E-MAIL**

Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

- a) **Practice will/may forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as**

**authorized or required by law.**

- b) **Practice may use email as a form of communication with other third parties, physicians and attorney(s) (applicant and defense) as it relates to patient's care and/or the resolution of any outstanding balances owed to Practice.**
- c) This consent will remain in effect until terminated in writing by either the patient or Practice.

### **3. PATIENT ACKNOWLEDGMENT AND AGREEMENT**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician(s), other parties, and me, and consent to the conditions and instructions outlined. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **The Dental Trauma Center** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

Witness signature \_\_\_\_\_

Date \_\_\_\_\_

# ADA Dental Claim Form

HEADER INFORMATION																																																																																										
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX																																																																																										
2. Predetermination/Preauthorization Number																																																																																										
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION																																																																																										
3. Company/Plan Name, Address, City, State, Zip Code																																																																																										
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code 13. Date of Birth (MM/DD/CCYY)      14. Gender <input type="checkbox"/> M <input type="checkbox"/> F      15. Policyholder/Subscriber ID (SSN or ID#)																																																																																										
16. Plan/Group Number      17. Employer Name																																																																																										
OTHER COVERAGE																																																																																										
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)																																																																																										
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)																																																																																										
6. Date of Birth (MM/DD/CCYY)      7. Gender <input type="checkbox"/> M <input type="checkbox"/> F      8. Policyholder/Subscriber ID (SSN or ID#)																																																																																										
9. Plan/Group Number      10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other																																																																																										
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code																																																																																										
PATIENT INFORMATION																																																																																										
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other      19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS																																																																																										
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code																																																																																										
21. Date of Birth (MM/DD/CCYY)      22. Gender <input type="checkbox"/> M <input type="checkbox"/> F      23. Patient ID/Account # (Assigned by Dentist)																																																																																										
RECORD OF SERVICES PROVIDED																																																																																										
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description				31. Fee																																																																																
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9																																																																																										
10																																																																																										
MISSING TEETH INFORMATION																																																																																										
34. (Place an 'X' on each missing tooth) <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <th colspan="16">Permanent</th> <th colspan="10">Primary</th> <th>32. Other Fee(s)</th> </tr> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td> <td>A</td><td>B</td><td>C</td><td>D</td><td>E</td><td>F</td><td>G</td><td>H</td><td>I</td><td>J</td><td></td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td>29</td><td>28</td><td>27</td><td>26</td><td>25</td><td>24</td><td>23</td><td>22</td><td>21</td><td>20</td><td>19</td><td>18</td><td>17</td> <td>T</td><td>S</td><td>R</td><td>Q</td><td>P</td><td>O</td><td>N</td><td>M</td><td>L</td><td>K</td><td>33. Total Fee</td> </tr> </table>										Permanent																Primary										32. Other Fee(s)	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee
Permanent																Primary										32. Other Fee(s)																																																																
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35. Remarks																																																																																										
AUTHORIZATIONS																																																																																										
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.  X _____ Patient/Guardian signature      Date																																																																																										
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.  X _____ Subscriber signature      Date																																																																																										
ANCILLARY CLAIM/TREATMENT INFORMATION																																																																																										
38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other																																																																																										
39. Number of Enclosures (00 to 99) Radiograph(s)   Oral Image(s)   Model(s)																																																																																										
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)																																																																																										
41. Date Appliance Placed (MM/DD/CCYY)																																																																																										
42. Months of Treatment Remaining      43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)																																																																																										
44. Date Prior Placement (MM/DD/CCYY)																																																																																										
45. Treatment Resulting from <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident																																																																																										
46. Date of Accident (MM/DD/CCYY)      47. Auto Accident State																																																																																										
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)																																																																																										
48. Name, Address, City, State, Zip Code																																																																																										
49. NPI      50. License Number      51. SSN or TIN																																																																																										
52. Phone Number ( ) -      52A. Additional Provider ID																																																																																										
TREATING DENTIST AND TREATMENT LOCATION INFORMATION																																																																																										
53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.  X _____ Signed (Treating Dentist)      Date																																																																																										
54. NPI      55. License Number																																																																																										
56. Address, City, State, Zip Code      56A. Provider Specialty Code																																																																																										
57. Phone Number ( ) -      58. Additional Provider ID																																																																																										