

**Nova Southeastern University - College of Dental Medicine
Oral Pathology Services**

Informed Consent for Treatment and Release of Information

By signing below, I understand that I am disclosing my medical information to Nova Southeastern University on behalf of its College of Dental Medicine for purposes of obtaining a diagnosis. I authorize NSU agents to discuss my information with other individuals to provide a consultation for second opinion.

I hereby give my consent for submission of any tissues removed during my treatment, to Nova Southeastern University, Oral Pathology Services for diagnostic purposes. This includes all appropriate laboratory tests

Patient name	Patient signature Guardian If Patient is under 18	Date
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I certify that the information given by me for payment under Title XVIII and /or Title of the Social security act is correct and request that payment of authorized benefits are made on my behalf. I understand that I am responsible for my health insurance deductibles, coinsurance and non-covered services. I also request the payment of authorized Medigap benefits, be made on my behalf to Nova Southeastern University Oral Pathology services.

Patient name	Patient signature Guardian If Patient is under 18	Date
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I hereby assume the responsibility to pay the costs of all services provided by Nova Southeastern University Oral Pathology Services.

Patient name	Patient signature Guardian if Patient is under 18	Date
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