

COLLEGE OF DENTAL MEDICINE Oral Pathology Services

Informed Consent for Treatment and Release of Information

University on behalf of it's College authorize NSU agents to discuss if for second opinion. I hereby, give my consent for subi	at I am disclosing my medical informations of Dental Medicine for purposes of obtains information with other individuals to mission of any tissues removed during manology Services for diagnostic purposes.	aining a diagnosis. I provide a consultation y treatment, to Nova
Patient Name	Patient Signature Guardian if Patient is under 18	Date
Security Act is correct and request understand that I am responsible f	by me for payment under Title XVIII and that payment of authorized benefits are or my health insurance deductibles, coin nt of authorized Medigap benefits, be ma blogy services.	e made on my behalf. I surance and non-covered
Patient Name	Patient Signature Guardian if Patient is under 18	Date
I hereby assume the responsibility University Oral Pathology service	y to pay the costs of all services provided es.	d by Nova Southeastern
Patient Name	Patient Signature Guardian if Patient is under 18	Date