NSU Florida

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 it's 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

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

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