TREATMENT CONSENT FORM

Dental Hygiene/Attn: Clinic Receptionist
Health and Human Services Building 515
North Washington Square, Suite 107
Lansing, MI 48933

Reception Phone: (517) 483-1458 Program Office Phone: (517) 483-1457 FAX: (517) 483-9925

- Having read the Patient Information Form and the Patient Rights and Responsibilities Form, I verify that I understand the information provided. I also understand the hazards and possible consequences involved in dental care in the LCC Clinic. I hereby consent to such treatment and agree to hold Lansing Community College, its agents, employees, and students, free and harmless from any claims, demands or suits for damages from any injury or complications which may result from this treatment.

- I further authorize the Lansing Community College Dental Hygiene Program to perform whatever preventative dental hygiene procedures and treatments are necessary for me as a patient, or for my dependent child, who is a patient. (This also applies to any person who has legal guardianship over another person.)

- I further authorize the college staff to use materials, including visual aids, pertaining to this case, for educational purposes.

- I understand that no warranty or guarantee has been made to me as to a result of cure of dental disease. I am aware that these preventative dental hygiene services performed in the clinic DO NOT TAKE THE PLACE of a regular comprehensive dental exam with a dentist and that I should have regular check-up examinations by a licensed dentist outside of being treated by the LCC Dental Clinic.

After reading the forms identified (Patient Information Form and Treatment Consent Form, Patient Rights and Responsibilities Form, and The Health and Information Privacy Act (HIPAA) form), please initial below that you understand each document.

Initial ____ I have read the Patient Information and Treatment Consent Form
Initial ____ I have read the Patient Rights and Responsibilities Form
Initial ____ I have read The Health and Information Privacy Act (HIPAA) Form

Please print your name, sign and date this document which indicates my commitment to the student's learning experience. As stated on the Rights and Responsibilities Form, my intention is to attend all appointments and call at **least 48 hours in advance** should I need to cancel my appointment so that the dental hygiene student can secure another patient.

_____ _____

Printed Name of Patient / Date

Signature of Patient (Parent or Guardian of a Minor Child or Legal Guardian of Other Individual)

_____

Verified by: (Student or Faculty) / Date
Dental Clinic Personnel Only Sign Here

AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION FORM

Dental Hygiene/Attn: Clinic Receptionist
Health and Human Services Building
515 North Washington Square, Suite 107
Lansing, MI 48933

Reception Phone: (517) 483-1458 Program Office Phone: (517) 483-1457 FAX: (517) 483-9925

The purpose of this form is to allow LCC Dental Hygiene Clinic, to release your confidential dental information to a third party. An example of such a reason would include the mailing of your radiographs to your private dentist or clinic. In order to provide us with your authorization, per the HIPAA Policies of the Dental Hygiene Program, you must complete the information listed below.

I,_____authorize LCC Dental Hygiene Clinic to release dental information to: (*Printed Name of* Patient*)*

☐ SEND BY MAIL OR ENCRYPTED EMAIL TO:

_____
Dentist, Clinic, Institution, Etc.

_____
Address or Email

_____
City, State, Zip Code

_____
Phone Number

☐ SEND BY MAIL OR ENCRYPTED EMAIL TO:

_____
Dentist, Clinic, Institution, Etc.

_____
Address or Email

_____
City, State, Zip Code

_____
Phone Number

NOTE: **Digital Films** can be sent directly to dentist office. If patient is requesting **Traditional films** be sent, duplicates will be sent and the original films will be kept at the LCC DH Clinic.

I,_____authorize LCC Dental Hygiene Clinic to release the following information: (*Printed Name of Patient)*

- ☐ Any portion of my dental record (preferred)
- ☐ Radiographs (Dental x-rays) only
- ☐ Periodontal Charting only

This release is in effect from the time of your signing this document. However, it may be revoked by you, the patient/guardian at any time, by providing verbal or written authority to us.

_____ _____

Signature of Patient or Legal Guardian/ Date Verified by: (Student or Faculty) / Date Dental Clinic Personnel Only Sign Here