

**South Shore Oral Surgery Associates, PC**  
**Steven J Verveniotis, DDS      Richard M. Mirra, DDS**  
**Diplomates of the American Board of Oral and Maxillofacial Surgery**

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**Please Initial each line and sign the bottom:**

\_\_\_\_\_ I authorize the release of any dental, medical or any other information including x-rays that may be requested by other professional offices.

\_\_\_\_\_ I authorize the release of any dental, medical or any other information including x-rays that may be necessary to process my insurance claim. (If applicable)

\_\_\_\_\_ I have been made aware by South Shore Oral Surgery that my records will be held in the strictest confidence according to the HIPPA privacy regulations.

\_\_\_\_\_ I authorize the release of any dental and medical information to my health proxy or family member: \_\_\_\_\_

\_\_\_\_\_ I am aware if my dental insurance requests a denial from my medical insurance carrier prior to processing my dental claim, that South Shore Oral Surgery **does not** participate with any medical insurance companies and **does not** file medical insurance forms. Therefore I am responsible for the fees and any attempt to recover funds from the medical insurance company.

\_\_\_\_\_ I am responsible for any remaining balance of my procedures that my insurance doesn't cover. (If applicable)

\_\_\_\_\_ If it is necessary for my account to be turned over to an attorney/collection agency I will assume all charges incurred by South Shore Oral Surgery.

**PRINT:** \_\_\_\_\_

**SIGN:** \_\_\_\_\_

**DATE:** \_\_\_\_\_