UNIVERSITY OF OREGON

University Health Center
UO Dental Clinic

Consent to Bill Dental Insurance

Assignment of Benefit and Release of Information:

I, _____, authorize any insurance benefits to be paid directly to the University of Oregon, University Health Center (UHC) and authorize UHC and/or my insurance carrier to release any information required for processing a claim. I understand that it is my responsibility to know my insurance coverage and benefits. I understand that it is my responsibility to immediately notify the UHC in the event of a change in insurance coverage.

I understand that I am ultimately responsible for the payment of any and all UHC charges, including balances not paid by my insurance carrier. I understand the balances will be transferred to my University of Oregon student account.

If covered by Oregon Medicaid programs such as the Oregon Health Plan (OHP), I authorize UHC to bill any identified private health insurance before billing OHP unless I have specifically requested, for reasons of confidentiality, that private insurance not be billed. In this situation, I understand that I will be responsible for the full cost of services and goods rendered.

I hereby consent to the University of Oregon, including any of its school officials, releasing my educational records (which refers to medical and dental records in this instance) as stated below:

Specific records to be released: Records related to: (1) bill third parties for health care services provided to me; or (2) paying for health care services provided to me.

Purpose of the release: To bill for or pay for health care services provided to me.

Party or class of parties to whom the records are being released: (1) Health care providers who have provided treatment to me; (2) Insurance companies that are obligated to pay for health care services to me; and

(3) Other third parties that process payment for health care services provided to me.

I understand that unless I revoke this consent in writing and deliver to the University Health Center, it shall remain in effect and my educational records will be disclosed as set forth above.

I have read and understand the University Health Center's release of records statement, which has been presented to me in writing and/or on the health center website, and I knowingly and voluntarily, provide my consent for records to be released as outlined in this document.

Name (please print): **UO ID#**

Signature: **Date:**