The University Of Minnesota School Of Dentistry
Cleft Palate / Craniofacial Clinics & VCFS / DiGeorge Clinic
Consent Form

Re:
(Patient Name)_________________

Authorization For Receiving and Sending Reports

I hereby grant permission to the staff of the Cleft Palate/Craniofacial Clinics & VCFS/DiGeorge Clinic to secure and/or release such reports and information as they deem appropriate to contribute to the welfare of
(patient name)__________________________

Authorization For Photographs, Radiographs and Transcriptions

I hereby authorize to the Cleft Palate/Craniofacial Clinics & VCFS/DiGeorge Clinic to photograph, record speech, and take radiographs that are necessary for the diagnosis and/or treatment of **(patient name)** __________________________and grant permission for their unidentified use for education and research purposes.

Clinic Fees Agreement

I understand it is the policy of the School of Dentistry to request that fees for service be paid in cash or by check as each services is provided.

If other than cash arrangements are to be made, I understand that arrangements can be made in the Patient Accounting Office, Room 7-530 Moos Health Sciences Tower. I also understand I am responsible to provide the necessary information and/or forms to the Patient Accounting Office if I have dental insurance coverage, am an eligible recipient of medical assistance program or if covered by another type of plan or program.

Signature_______________________________________ **Date**______________
Patient or parent / guardian if patient is under age 18