ORAL & MAXILLOFACIAL ASSOCIATES, INC.

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION

Patients Name: _____

Date of Birth:_____

SSN:_____

My protected health information is private and confidential. I understand that my doctor and his/her staff work very hard to protect my privacy and preserve the confidentiality of my protected health information.

I understand that my doctor and his/her staff may use and disclose my protected health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his/her staff would follow the agreed limits.

I may cancel this consent at any time by doing one of the following:

1) Signing and dating a form that my doctor or his/her staff can give me called “Revocation of Consent for Use and Disclosure of Health Information”, or
2) Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my protected health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his/her staff do not have to provide any further health care services to me.

My doctor has a detailed document called the “Notice of Privacy Practices”. It contains more information about the policies and practices protecting my privacy. I understand that I have the right to read the “Notice” before signing this agreement. My doctor may update this “Notice”. If I ask, my doctor or his/her staff will provide me with the most current “Notice” and the current “Notice” will always be posted at my doctor’s office.

My signature below indicates that I have been given the chance to review a current copy of my doctor’s “Notice of Privacy Practices”. My signature means that I agree to allow my doctor to use and disclose my protected health information to carry out treatment, payment, and healthcare operations.

_____ _____

Patient (or legally authorized individual) signature Date

_____

Relationship to patient (parent, legal guardian, etc.)