Consent for Disclosure of Health Care Information

Patient's name: _____ Date of Birth: _____

SSN: _____ Previous or maiden name: _____

Practice name: EAST TEXAS ORAL & MAXILLOFACIAL SURGERY ASSOCIATES

My personal 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 personal information.

I understand that my doctor and his/her staff may use/disclose my personal health information to help provide healthcare to me, to handle billing and payments and to take care of other healthcare operations. There will be no other uses or 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 personal 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 and his/her staff can give me that is called "Revocation of Consent of 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 personal 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 healthcare service to me.

My doctor has a detailed document called the "Notice of Private 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 and if I ask, my doctor and his/her staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctors office. My signature below indicates that I have been given the chance to review a current copy of my doctors "Notice of Privacy Practice." My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment, payment and healthcare operations.

_____ _____

Patient (or legally authorized individual) signature Date

_____

Relation to patient (parent, legal guardian)