Dr Harold Patino
Oral Maxillofacial
& Implant Surgery

Notice of Privacy Practices Acknowledgement & Patient Consent to Disclose

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- Conducting standard healthcare operations;
- Confirmation of appointments/messages may be left on voicemails to deliver pre-operative instructions. These instructions may also be left with any person that answers the phone number provided to this office.

I have also been given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are bound to comply with this restriction(s).

I authorize information in regards to my health/accounting issues to be discussed with the following person/people. **PLEASE PRINT.**

1. _____ Relationship: _____ Cell #_____

2. _____ Relationship: _____ Cell #_____

At any time I have a right to change this request. I understand that it must be submitted in writing.

I decline to have messages left on my: OFFICE_____ HOME _____ CELL _____

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to this date I revoked this consent is not affected.

Print Name of Patient / Parent / Or Guardian: _____ Date: _____

Relationship to Patient: Self _____ Parent _____ Guardian _____ Other _____

Signature: _____ Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgment,* but was unable to do so as documented below:

Staff: _____ Date: _____

Reason: _____

_____