PRESTIGE®
ORAL & FACIAL SURGERY CENTER

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PATIENT PRIVACY FORM

Patient's Name: _____

This form is optional under the new patient privacy regulations recently issued by the United States Department of health and Human Services. We have elected to use this form, prior to begin your treat

This Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

Your protected health information (i,e., names, dates, phones numbers, email address, home address, social security, etc.) may be used in connection with your treatment, payment of your account or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

I, _____ as a patient or patient's guardian in Prestige Oral and Facial Surgery Center, authorize the medical information regarding my treatment and care to be discussed with the following individuals.

Name of Patient: _____ Sign: _____ Date: _____

Authorized Recipient: _____ Sign: _____ Date: _____