I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I consent to the disclosure of my health records to any providers involved in my care or treatment, to health plans, to others as needed for payment purposes, to others as needed to improve the quality of my care and experience and/or to manage The Oral Surgery Center’s business operations. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by The Oral Surgery Center of the practice’s Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been offered a copy of the Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that The Oral Surgery Center restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that The Oral Surgery Center is not required to accept requested restrictions but if agreement is approved, The Oral Surgery Center is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that The Oral Surgery Center has taken action relying on this consent.

HIPAA Privacy issues can arise when using cell/smart phones in areas of The Oral Surgery Center where patients and/or patient information may end up in photos or audio recordings. Patients and/or discussions may be in the background, and this information may be picked up in the photo or audio recording.

To ensure confidentiality and privacy, the use of camera phones and personal digital assistants (PDAs) for the purpose of video-taping patients for non-clinical purposes is strictly prohibited.

Patient Name: ____________________________________________

Signature: ________________________________________________

Relationship to Patient: ________________________________

Right of Access for Family Member/Friend
In addition to the disclosures outlined above, I direct The Oral Surgery Center to disclose and release my protected health information described below to:

Family Member/Friend Name: _______________________________

Information to be Disclosed: ________________________________

Date: ____________________________________________________