Simmonds, Brady & Loi
ORAL & MAXILLOFACIAL SURGERY AND IMPLANT SPECIALISTS, P.C.

PATIENT PRIVACY CONSENT FORM

PATIENT'S NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ESTABLISHED A PRIVACY RULE TO HELP INSURE THAT PERSONAL HEALTH CARE INFORMATION IS PROTECTED FOR PRIVACY. THE PRIVACY RULE WAS ALSO CREATED IN ORDER TO PROVIDE A STANDARD FOR CERTAIN HEALTH CARE PROVIDERS TO OBTAIN THEIR PATIENTS' CONSENT FOR USES AND DISCLOSURES OF HEALTH INFORMATION ABOUT THE PATIENT TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS.

AS OUR PATIENT, WE WANT YOU TO KNOW THAT WE RESPECT THE PRIVACY OF YOUR PERSONAL DENTAL AND MEDICAL RECORDS AND WILL DO ALL THAT WE CAN TO SECURE AND PROTECT THAT PRIVACY. WE STRIVE TO ALWAYS TAKE REASONABLE PRECAUTIONS TO PROTECT YOUR PRIVACY. WHEN IT IS APPROPRIATE AND NECESSARY, WE PROVIDE THE MINIMUM REQUIRED INFORMATION TO ONLY THOSE WE FEEL ARE IN NEED OF YOUR HEALTH INFORMATION; INFORMATION REGARDING TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS, IN ORDER TO PROVIDE CARE THAT IS IN YOUR BEST INTEREST.

WE WANT YOU TO KNOW THAT WE SUPPORT YOUR FULL ACCESS TO YOUR DENTAL AND MEDICAL RECORDS. OUR OFFICE MAY HAVE INDIRECT RELATIONSHIPS WITH YOU, AND MAY NEED TO DISCLOSE PERSONAL HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THESE ENTITIES ARE MOST OFTEN NOT REQUIRED TO OBTAIN PATIENT CONSENT.

YOU MAY REFUSE TO CONSENT TO THE USE OF OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION, BUT THIS MUST BE DONE IN WRITING. UNDER THIS LAW, WE HAVE THE RIGHT TO REFUSE TO TREAT YOU SHOULD YOU CHOOSE TO REFUSE TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION. IF YOU GIVE CONSENT IN THIS DOCUMENT, AT SOME FUTURE TIME YOU MAY REQUEST IN WRITING TO THIS OFFICE TO REFUSE ALL OR PART OF YOUR PERSONAL HEALTH HISTORY. YOU MAY NOT REVOKE ACTIONS THAT HAVE ALREADY BEEN TAKEN WHICH RELIED ON THIS OR A PREVIOUSLY SIGNED CONSENT.

SIGNATURE OF PATIENT/LEGAL GUARDIAN DATE