Authorization for Release of Individually Identifiable Health Information to Designed Party

Patients Last Name	Patient First Name	MI	Date of Birth	Social Security Number

This authorization grants permission to the designated party(ies) named below to all of the following:

- *Make or confirm appointments*
- ** Verbal access to x-ray, laboratory, test findings, diagnosis, prognosis, and treatment plans by telephone or other common means of communication*
- *Access to my financial information*

I hereby authorize Oral Surgical Associates to use and disclose my individually identifiable health information as described above. The following lists of people are the people I have designated to receive my individually identifiable health information. I understand that this authorization is voluntary. I understand that once this information is disclosed to the designated party(ies) named below, the release of information may no longer be protected by federal privacy regulations. I understand an authorization for release of information will need to be signed if a photocopy of my record is required.

PLEASE PRINT THE INFORMATION BELOW:

NAME	RELATIONSHIP	ADDRESS	TELEPHONE NUMBER

I understand that this authorization will be effective for the lifetime of the patient unless revoked in writing.
I understand that I may revoke this authorization at any time by notifying the Medical Records Department in writing: however, the revocation will have no effect on disclosures made prior to the receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization.
I authorize messages to be left on my personal answering devices regarding my protected health information.

- ☐ Yes
- ☐ No

Signature of Patient ______ Date ______

Printed Name of Patient's Legal Representative ______ Relationship ______

Signature of Patient's Legal Representative ______ Date ______

What is your preferred method of contact?

- ☐ Landline
- ☐ Cell Phone
- ☐ Email

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I have been offered a copy of this office's Notice of Privacy Practices.

Signature ______ Date ______

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

______ Refused to sign

______ Communications barriers prohibited obtaining the acknowledgement

______ An emergency situation prevented us from obtaining acknowledgement

______ Other (please specify) ______

EMAIL CONTACT INFO: ______

Oral Surgical Associates will use this for appointment purposes only; we will not use your email for any other purpose other than to contact you.