CRYSTAL COAST
ORAL & FACIAL SURGERY

HIPAA/Authorization for Release of Information

Name of Patient: _____ Date of Birth: _____

Crystal Coast Oral & Facial Surgery is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

May we leave a voicemail for you that includes sensitive information? ☐ YES ☐ NO
(If yes, please list the phone number where a message may be left.) (_____)-_____-_____

May we discuss your information with others such as a Spouse or Parent?
(If yes, please provide name and phone number below and select applicable box(es) to the right.)

NAME	PHONE NUMBER		
_____	_____	☐ **Financial**	☐ **Medical**
_____	_____	☐ **Financial**	☐ **Medical**
_____	_____	☐ **Financial**	☐ **Medical**

May we send you information via email?* ☐ **Financial** ☐ **Medical**
(If yes, please provide email address below and select applicable box(es) to the right.) ☐ **Breach Notification**

_____

**For email communications to occur, accept the disclosure below:*

☐ **For email communication, I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email communication as selected.**

Patient Medical Records

We may need to obtain medical records such as medications list, clinical notes and/or recommendations from your physician in order to provide the best possible care at our office. If you do not want us to contact your physician, please disclose this to us at time of your exam. Signing this document allows us to contact your physician and obtain records needed for continued care at our office.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ _____
Signature of Patient or Personal Representative **Date**

***Description of Personal Representative's Authority (attach necessary documentation)**