PIEDMONT ORAL SURGERY

DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date:_____

By law, medical information is considered confidential unless written authorization to disclose information is given. This does not include any request we may receive concerning your treatment by our physician or facility. This also does not pertain to any information requested from an insurance company in payment of a claim. Therefore, upon signing this form, I, _____am authorizing Piedmont Oral Surgery, P.A. to release medical information as described below to:

Name:_____Phone#:_____Relationship:_____

Name:_____Phone#:_____Relationship:_____

I give permission for Piedmont Oral Surgery, P.A. to release the following information:

Scheduled appointment times: Yes____ No_____

Bill and account information: Yes____No_____

May we call you at home?

Yes_____

No_____-If no, please provide alternate phone contact information:_____

May we leave you a voice mail?

Yes____No____

May we mail any correspondence pertaining to your medical care to your home address?

Yes_____

No_____-If no, please provide alternate mailing address: _____

_____

This authorization remains in effect until I give written notification to discontinue. By signing, I acknowledge I received a copy of the HIPPAA policy.

_____ _____

Signature of Patient Date

FAX AND E-MAIL PRIVACY WAIVER AND CELL PHONE CONSENT

I understand that my medical records may be transmitted electronically by fax and may be received in error by a third party. In the event that this should occur, I absolve the practice of all liability.

I give my consent to fax my records for the purpose of treatment, payment or healthcare operations and understand that I may withdraw this consent at any time in writing.

If I choose to e-mail my healthcare provider(s), I understand that e-mail is considered a convenience and is not appropriate for emergencies, or time-sensitive issues. I also understand that highly sensitive or personal information should not be communicated via e-mail.

I understand that although safeguards will be made to protect the confidentiality of any information contained within e-mail, no one can guarantee the absolute privacy of e-mail messages and that depending on their job function, staff may have the right to access any e-mail sent or received by my healthcare provider(s).

I therefore give my consent to include any e-mails pertinent to the treatment, payment, or healthcare operations in my medical record. Finally, I understand that I may withdraw the consent at any time in writing.

I give my consent to allow Piedmont Oral Surgery, P.A. to call my cell phone for a contact number and also allow agencies to call my cell phone on behalf of Piedmont Oral Surgery, P.A. for accounts turned over for collections.

_____ _____

Signature of Patient Printed Name of Patient