FACE AND JAW SURGEONS, PC
HIPAA AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. This form summarizes the anticipated use of information about you for which an Authorization is required. Face and Jaw Surgery Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient's Name: _____ Date of Birth: _____
Previous Name(s): _____ SSN: _____

Specific health information to be disclosed related to the following treatment, condition, and/or dates:
_____
_____

Individuals who may disclose this information: _____

Individuals who may receive the disclosed information: _____
_____

If the disclosed information is to be sent by U.S. mail or fax, please provide the necessary information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ FAX: _____

Expiration date or expiration event of this authorization: _____
_____

The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and thus may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. **You have the right to revoke this authorization at any time in writing signed by you.** However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

If you refuse to sign this Authorization, we may not withhold treatment, except that (a) we may withhold research-related treatment if you refuse to supply authorization for the use or disclosure of your information for such research, and (b) we may withhold treatment that is being furnished solely for purposes of creating protected health information for disclosure to a third party (such as a life insurance company exam or school physical), where disclosure to the third party requires execution of this Authorization.

This authorization was signed by:

_____ _____
Patient or Representative Signature Date

Basis for Representative's Authority to sign for Patient (e.g. parent, legal guardian): _____
_____