NJOS

NJ CENTER FOR ORAL SURGERY

PATIENT CONSENT FOR RELEASE OF HEALTH INFORMATION (HIPAA Authorization Form)

Patient Information:
Full Name: _____
Date of Birth: _____
Phone Number: _____
Address: _____
City: _____ State: ____ ZIP: _____

Authorization to Release Protected Health Information (PHI)

I hereby authorize the use or disclosure of my protected health information as described below. I understand that this authorization is voluntary and that it will not affect my ability to receive medical care.

1. Person/Organization Authorized to Disclose Information:
(Name or Facility):

(Address, phone, fax, email):

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2. Information to Be Disclosed:
☐ Complete Medical Record
☐ Billing Records
☐ Laboratory Results
☐ Imaging
☐ Doctor's Notes
☐ Other (please specify): _____

3. Purpose of Disclosure:
☐ Continuity of Care
☐ Legal
☐ Insurance
☐ Personal Use
☐ Other (specify): _____

Patient Rights:

- I understand I have the right to revoke this authorization at any time by providing a written notice to the disclosing party.
- I understand that revocation will not affect any disclosures made prior to the revocation.
- I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

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Signature
I have read and understand the terms of this authorization and hereby authorize the release of my health information.

I understand there is a reproduction fee of $10 for each radiograph and $1 per page, plus postage. Duplicate copies of CT scans on a disc are available for a $10 fee. There is no charge to forward radiographs to the dentist(s) you listed on your registration forms or to provide you with an initial CD of any CT scans obtained at our office.

All information sent by email will be encrypted to comply with HIPPA regulations. The recipient must follow the instructions accompanying the email in order to open it.

This release is valid from the date that I have placed my signature below until such time that I cancel by notifying the office in writing. Furthermore, I agree to hold the doctor, their employee(s) or agents harmless should the release of this information in anyway cause harm to me.

Signature of Patient or Legal Representative: _____

Printed Name: _____

Relationship to Patient (if not self): _____

Date: ___ / ___ / _____

Office Use Only
Received/Verified by: _____ Date: ___ / ___ / _____
ID Verified: ☐ Yes ☐ No
Method: ☐ In person ☐ Phone ☐ Other: _____