Northtowns Oral and Maxillofacial Surgery, PLLC
Glen C. Donnarumma, DDS
Steven Vukas, DMD, MD

HIPAA Consent Form
Acknowledgment of Receipt of Notice of Privacy Practices

Dear Patient:

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member, such as a spouse, a significant other, a parent or a sibling, you must indicate the name of the specific person(s). **WE WILL BE UNABLE TO RELEASE ANY INFORMATION TO ANYONE OTHER THAN WHO IS INDICATED ON THIS FORM.**

I,_____, hereby give my permission for the staff of
(Print your name)

Northtowns Oral and Maxillofacial Surgery to release medical information about myself to:

_____
(Name of person you are authorizing) (Relationship)

_____
(Name of person you are authorizing) (Relationship)

I can cancel this authorization at anytime, in writing, and have been offered a copy of this office's Notice of Privacy Practices which explains their HIPAA policies.

Signature_____

Date Signed_____

If you **do not** want to authorize the release of medical information to any individual, please sign below.

I,_____, decline to have any medical information,
(Print your name)

in regards to myself, released to any individual.

Signature_____ Date Signed_____