Northtowns Oral and Maxillofacial Surgery, PLLC
HIPAA Consent Form

It is necessary for us to have written consent in your medical file if you want us to be able to communicate any information about yourself to another individual. If you want us to release information to a family member such as a spouse, significant other, parent or sibling, you must indicate the name of the specific person(s). **It is not necessary to list dentists and/or doctors who are currently treating you. 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 any time, and I acknowledge that I have been offered a copy of this practice's Notice of Privacy Practices which explains their HIPAA policies.

Signature_____ Date_____

Fill in the portion below if you DO NOT want us to communicate any information:

I, _____, **do not** authorize the release of medical
(Print your name)
information to any individual, and I acknowledge that I have been offered a copy of this practice's Notice of Privacy Practices which explains their HIPAA polices.

Signature_____ Date_____

Consent for Communication

Northtowns Oral & Maxillofacial Surgery, PLLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur.
Please check the appropriate boxes below as to how we may communicate with you:

- □ Text Message (appointment and surgery instruction reminders)
- □ Leave voicemail (appointment and surgery instruction reminders)
- □ Encrypted email (new patient paperwork, treatment plans, billing statements)
  Email address_____

Signature_____ Date_____