HIPAA RECEIPT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I authorize *Semmel Oral & Facial Surgery* to disclose personal medical information to the following people:

______________________________	______________________________
Name	**Relationship**
______________________________	______________________________
Name	**Relationship**
______________________________	______________________________
Name	**Relationship**

☐ **Yes** ☐ **No** **I authorize *Semmel Oral + Facial Surgery* to leave voice messages.**

______________________	______________________	______________________
****Patient Name PRINTED**	****Patient Signature**	****Date**

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Patient