

Alliance Oral & Maxillofacial Surgery, P.A.

Patient Name: _____

Due to Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be filled out by each patient annually. TODAY'S DATE: _____.

I authorize Alliance Oral & Maxillofacial Surgery, to release any of my medical or insurance information necessary to process my medical claims and coordinate or manage my health care.
O YES / O NO

In the event a family member or caregiver attends your office visit and is in the exam room at the time of your evaluation, I give Alliance Oral & Maxillofacial Surgery and it's physicians or employees my permission to discuss freely my condition, treatment, or diagnosis with that person. O YES / O NO

I authorize Alliance Oral & Maxillofacial Surgery to leave a voice messages with treatment information in case I can't be reached to discuss at the moment of the call.

HOME PHONE: _____ Leave a message: O YES / O NO

WORK PHONE: _____ Leave a message: O YES / O NO

CELL PHONE: _____ Leave a message: O YES / O NO

May we call your name out loud in our lobby? O YES / O NO

With whom may we discuss or release information about your care and treatment?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

With whom may we not discuss or release any information about your care and treatment?

Name: _____ Relationship: _____

Patient or Authorized Representative Signature: _____

(Signature is valid one year from date shown above)

Printed Name: _____

Alliance Oral and Maxillofacial Surgery, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's
Notice of Privacy Practices.

Patient or Authorized Representative Signature

Print Name

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)
