NORTH PITTSBURGH ORAL SURGERY

Oral & Maxillofacial Surgery

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION HEALTH INSURANCE AND ACCOUNTABILITY ACT (HIPAA)

I hereby give my consent for North Pittsburgh Oral and Maxillofacial Surgery Associates (NPOSA) to use and disclose protected health information about me to carry out treatment, payment and health care operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent. NPOSA reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to North Pittsburgh Oral and Maxillofacial Surgery Associates, 9380 McKnight Rd. Suite 203 Pittsburgh, PA 15237.

With this consent, NPOSA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or other health care operations (TPO), such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, NPOSA may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, NPOSA may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that NPOSA restrict how it uses or discloses my protected health information (PHI) to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow NPOSA to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NPOSA may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

_____ _____

Print Patient's Name Date