Beverly Hills Oral and Maxillofacial Surgery Institute

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HIPAA PRIVACY RULES

Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, *Beverly Hills Oral & Maxillofacial Surgery Institute* originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and treatment information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I have been provided with a copy (on the web site, or on paper) of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I have the right to review the notice prior to providing my authorization. I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review *Beverly Hills Oral & Maxillofacial Surgery Institute's* Notice of Privacy Practices prior to providing my consent;
- *Beverly Hills Oral & Maxillofacial Surgery Institute* reserves the right to change the notice and practices and that prior to implementation will post or mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that *Beverly Hills Oral & Maxillofacial Surgery Institute* is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that *Beverly Hills Oral & Maxillofacial Surgery Institute* has already taken action in reliance thereon;
- It is *Beverly Hills Oral & Maxillofacial Surgery Institute's* procedure to share Protected Health Information with labs, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange the minimum necessary Protected Health Information for each transaction.

Please sign the *Patient Information* form to acknowledge these rules.