Notice of Privacy Practices for Protected Health Information

Southern Oral Surgery strongly believes in protecting the confidentiality and security of information we collect about you. This notice describes our privacy policy and describes how we treat the protected health information we receive about you.

How We Protect Information: We treat information in a confidential manner. Staff is required to protect the confidentiality of information. Staff may access information only when there is an appropriate reason to do so.

Information Disclosure: With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Your Health Information Rights: The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you.

1) I understand that I may inspect or obtain a copy of the protected health information described by this authorization by delivering a written request to Southern Oral Surgery.
2) I understand that I may revoke this authorization at any time by delivering a request in writing to Southern Oral Surgery. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
3) I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.
4) I understand that Southern Oral Surgery may have the opportunity to obtain direct or indirect remuneration from a third party as a result of this authorization.
5) I understand that Southern Oral Surgery reserves the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy or from our website, www.southern-oralsurgery.com.

Print Patient's Full Name: _____ Date of Birth ____/____/____

I hereby acknowledge that I have read a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

____/____/____ _____ _____

Date Signature of Patient or Parent/Guardian Relationship to Patient

(THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM NOW)