Valley Oral Surgery, P. C.

Larry R. Meador, DDS

Diplomat American Board of Oral and Maxillofacial Surgery

PATIENT HIPAA CONSENT FORM

OUR PRACTICE HAS ALWAYS MADE EVERY EFFORT TO PROTECT THE CONFIDENTIALITY OF YOUR PERSONAL HEALTHCARE INFORMATION. EFFECTIVE APRIL 14, 2003, THE LAW REQUIRES THAT WE POST A NOTICE OF PRIVACY PRACTICES AND THAT WE HAVE YOUR SIGNATURE ON FILE ATTESTING THAT YOU HAVE BEEN NOTIFIED OF OUR PRIVACY PRACTICES. THE NOTICE OF PRIVACY PRACTICES IS POSTED IN OUR WAITING ROOM. A COPY OF THIS NOTICE, IN LARGER PRINT, IS ALSO AVAILABLE TO YOU UPON REQUEST FROM OUR RECEPTIONIST.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains certain rights you have 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).

The patient understands that:

- **Protected health information may be disclosed or used for treatment, payment or health care operations.**
- **The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.**
- **The Practice reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.**
- **The patient may revoke this Consent in writing at any time and all future disclosures will then cease**
- **The Practice may condition treatment upon the execution of this Consent**

Signature of Patient or Legal Guardian:____

Relationship to Patient (if other than patient):____

Signature of Representative):____

Date____

Revised 9/23/13