Southern Ohio Oral & Facial Surgeons, Inc.
Patient Consent and Authorization

Patient Name: ______________________________

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are required to agree to my requested restrictions, and if agreed, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Consent for Evaluation and/or Treatment
By signing below, I am giving my consent to Southern Ohio Oral & Facial Surgeons, Inc. for evaluation and/or treatment. Once I have been examined, I understand that I will be informed of any medically recommended diagnostic procedures and/or treatments and given the option to accept or decline. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Signature of patient or patient's guardian:________________________
Date:_____________________________

Please list the person(s) with whom we can discuss your health information.

Signature of patient or patient's guardian:________________________
Date:_____________________________