UPSTATE
Oral & Maxillofacial Surgery
& Dental Implant Center

This authorization form permits Upstate Oral & Maxillofacial Surgery & Dental Implant Center, P.A. to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

Name _____ Date of Birth _____

Entity or person to receive information **Voicemail Number**: _____	Description of information to be provided: ☐ Appointment Information ☐ Financial Information ☐ Family Billing Information ☐ Clinical Information – Please list: _____
Entity or person to receive information **Unsecured Email Address**: _____	Description of information to be provided: ☐ Appointment Information ☐ Financial Information ☐ Family Billing Information ☐ Clinical Information – Please list: _____
Entity or person to receive information **Any Treating Facility is authorized to receive unencrypted email PHI**	Description of information to be provided: ☐ Unencrypted PHI for Treatment
Entity or person to receive information **Parent, give name**: _____	Description of information to be provided: ☐ Appointment Information ☐ Financial Information ☐ Family Billing Information ☐ Clinical Information – Please list: _____
Persons allowed to be present during evaluation and treatment: _____ _____	Persons allowed to be present during evaluation and treatment: _____ _____
Entity or person to receive information **School or Employer**: _____	Description of information to be provided: ☐ Appointment Information ☐ Return to work or school document

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Entity or person to receive information	Description of information to be provided:
Other, give name and relationship: _____	☐ Appointment Information ☐ Financial Information ☐ Family Billing Information ☐ Clinical Information – Please list: _____

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration Date or Event

This authorization shall be enforced until revoked by the patient or _____.

Verification method or code

This practice will verify the identity of any entity requesting protected health information. Verification information may include: _____

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed, but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative (as defined by HIPAA) Date

Description of Personal Representative's Authority (Attach necessary documentation.)

Office Use Only:

Receiving Employee _____ Date Received _____

☐ Copy given to patient