Gonzalez & Carr
Oral Facial Surgery

HIPAA

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal healthcare information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosures of health information about the patient to carry out treatment, payment, or healthcare operations.

As our patient, we want you to know that we respect the privacy of your personal medical/dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When appropriate, we provide the minimum necessary information to only those we feel are in need of your health care information. This includes information about treatment, payment and/or health care operations in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical/dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, if you refuse to disclose your Personal Health Information, we have the right to refuse to treat you. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice (which is available at the front desk), to request restrictions, and revoke consent in writing.

I authorize the following person(s) to communicate on my behalf with Gonzalez & Carr, PC concerning my medical care (you may attach additional sheets as necessary):

Name:_____Relation:_____

Name:_____Relation:_____

Name:_____Relation:_____

INSURANCE REFERRALS / BENEFITS:
In addition, I have been informed by the office of Gonzalez & Carr, PC that my insurance benefits may or may not cover my diagnosis or services rendered. Also, any insurance referrals are my responsibility and failing to obtain required referrals will result in all charges being my responsibility. I may be asked to pay in full at the time of services rendered and if insurance offers benefits I will be reimbursed by same. Any insurance questions or disputes are my responsibility to handle.

PATIENT NAME (please print)_____

SIGNATURE **X**_____

RELATIONSHIP TO PATIENT_____

DATE_____

WITNESS**X**_____

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