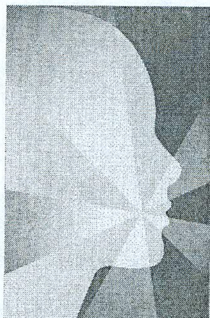
HIPAA Patient Consent



Dr. Bruce J. Cutilli
Oral & Maxillofacial Surgery, LLC
809 North Bethlehem Pike, PO Box 857
Spring House, PA 19477

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

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

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been provided the *Notice Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care options. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide such restrictions.

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

Patient Name (print)____

Patient Signature ____

Parent Signature ____
(If patient is a minor)

I understand that it is your office policy not to discuss my treatment with anyone that I have not authorized in writing. I would like to authorize Dr. Cutilli and his staff permission to discuss issues relating to my treatment with the following people and/or leave messages regarding my treatment at the phone numbers listed below:

Name:__________________________________ Phone:________________________

Name:__________________________________ Phone:________________________

Date _________________________