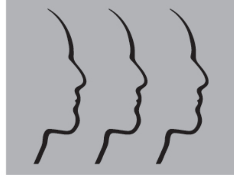

Bothell

Oral, Maxillofacial & Implant Surgery

18807 Beardslee Blvd., Suite 102
Bothell, WA 98011
(425) 489-8274

Notice of Privacy Practice Acknowledgement and Release of Information Authorization

Our Notice of Privacy Practices describes in more detail how your protected health information may be used and disclosed and how you can access your information. Please ask to see a copy of this document at any time. You have a right to review the 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.

We keep a record of the health care service we provide to you. You may ask to see and copy the record and you may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. We are not required to agree with this restriction, but if we do, we shall honor that agreement. You have a right to revoke this consent in writing, signed by you. However such revocation shall not affect any disclosures we have already made in reliance to your prior consent.

Further, I authorize Bothell Oral, Maxillofacial & Implant Surgery, as needed, to discuss my health care, treatment, and financial arrangements with the individuals indicated below:

- ☐ Anyone in my immediate family
- ☐ My Spouse
- ☐ My Mother/Stepmother/Guardian
- ☐ My Children/Stepchildren
- ☐ My Father/Stepfather/Guardian
- ☐ My Employer
- ☐ My Insurance Company(s)
- ☐ My Escort (health care attendant)
- ☐ Individual transporting me after surgery (pertinent health care & treatment information only)
- ☐ Other: ____

☐ I give permission for Bothell Oral, Maxillofacial & Implant Surgery to leave a detailed message about my upcoming appointment, including time, date, and medications needed, with someone at my home, on my voicemail recorder

- ☐ Or on a voicemail at my place of employment.
- ☐ Or on my cellular telephone.

By my signature below, I acknowledge receipt of this disclosure and authorize discussion of my health care and related issues as indicated above.

____ __________________

Patient Name (please print) **Date**

____

Signature of patient (or legally authorized individual)

____

Printed name of signer (if not patient)

This form will be retained in the patient's record