SOUTHERN WEST VIRGINIA
ORAL & MAXILLOFACIAL SURGEONS, LTD

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

** You May Choose Not to Sign this Acknowledgment **

I, _____, acknowledge that I have reviewed the *Notice of Privacy Practices* for Southern West Virginia Oral & Maxillofacial Surgeons, LTD. I have read and understand how my protected health information is used and/or disclosed for purposes of treatment, payment, and health care operations.

I authorize Southern West Virginia Oral & Maxillofacial Surgeons, LTD to speak to the following person(s) concerning my appointments and/or treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I acknowledge that the person(s) listed above will be required to provide some form of identifying information of mine (DOB, SSN, etc.) to facilitate communication. I understand that this Authorization does not designate permission to release my protected health information in writing, and that I can revoke this authorization at any time by writing to: Privacy Officer, Southern West Virginia Oral & Maxillofacial Surgeons, LTD, 807 Broad Street, Summersville, WV 26651

_____ _____

Patient Printed Name **Patient or Parent/Guardian Signature**

_____ _____

Signatory Relationship to Patient **Date**

OFFICE USE ONLY:

☐ Individual refused to sign.

☐ Communication barriers prohibited obtaining the Authorization.

☐ An emergency situation prevented us from obtaining the Authorization.

Team Member Initials: _____