

# Maxillofacial and Facial Aesthetic Surgery, LTD.

## Authorization for Disclosure of Health Information

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

Name: **Maxillofacial & Facial Aesthetic Surgery, LTD.**

Address: **426 South 3<sup>rd</sup> Street** City: **Geneva** State: **Illinois** Zip: **60134**

3. The type and amount of information to be used or disclosed is as follows: (include dates if/where appropriate).

All Health Care Information or:

<input type="checkbox"/> Complete health records	<input type="checkbox"/> Prescription refills/issues	<input type="checkbox"/> Post-operative calls
<input type="checkbox"/> Physical Exam	<input type="checkbox"/> Financial/Insurance issues	<input type="checkbox"/> Diagnosis related issues
<input type="checkbox"/> Lab results/X-ray reports	<input type="checkbox"/> Surgical appointment verification	<input type="checkbox"/> Others (please specify):

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual(s) or organization(s) (If household is acceptable to disclose information, including answering machine, please write "HOUSEHOLD" below).

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

Additional names authorized for release of above information: \_\_\_\_\_

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Dr. Kevin R. Haddle. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ONE YEAR FROM THE DATE IT IS SIGNED BY THE PATIENT OR LEGAL REPRESENTATIVE.
7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact: **Dr. Kevin R. Haddle**

Privacy Officer for: **Maxillofacial and Facial Aesthetic Surgery, LTD.**

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
Signature of witness

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE NOTE:** This information has been disclosed to you from confidential records protected from disclosure by state and federal law. No further disclosure of this information should be done without specific, written and informed release of the individual to whom it pertains or as permitted by state law (ORC – 3701.243) and federal law 42 CFR, part II.