CONSENT FOR DISCLOSURE OF HEALTH CARE INFORMATION
Howard R. Strauss, D.D.S., P.A./Western Maryland SurgiCenter

Patient's Name _____ Account number _____

Date of Birth _____ SSN _____

My personal health information is private and confidential. I understand that my doctor and his staff work very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that my doctor and his staff may use and disclose my personal health information to help provide health care to me, to handle billing and payment, and to take care of other health care operations. I request payment of medical and dental benefits, including authorized Medicare, be made on my behalf for any covered services furnished me by Dr. Howard Strauss. I also authorize the release of any information needed to determine these benefits. There will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission.

I can ask my doctor to limit how my personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my doctor does not have to agree to my request. If my doctor does agree to my request, I understand that my doctor and his staff would follow the agreed limits.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

_____Home Telephone_____
_____OK to leave a message with detailed information
_____Leave message with callback number only

_____Work Telephone_____
_____OK to leave message with detailed information
_____Leave message with callback number only

_____Written Communication
_____OK to mail to my home address
_____OK to mail to my work/office address
_____OK to fax to number indicated
_____Other (fax, cell, etc)_____

_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

_____Spouse_____
_____Parent_____
_____Child_____
_____Other (specify):_____

I may cancel this consent at any time by doing one of the following:

1. Signing and dating a form that my doctor or his staff can give me called "Revocation of Consent for Use and Disclosure of health Care Information" or
2. Writing, signing, and dating a letter to my doctor directly. If I write a letter, it must say that I want to cancel my consent to authorize the use and disclosure of my personal health information for treatment, payment, and healthcare operations.

If I cancel this consent, my doctor and his staff do not have to provide any further health care services to me.

My doctor has a detailed document called the "Notice of Privacy Practices." It contains more information about the policies nad practices protecting my privacy. I understand that I have the right to read the "Notice" before signing this agreement. My doctor may update this "Notice." If I ask, my doctor or his staff will provide me with the most current "Notice" and the current "Notice" will always be posted at my doctor's office.

My signature below indicates that I have been given the chance to review a current copy of my doctor's "Notice of Privacy Practices." My signature means that I agree to allow my doctor to use and disclose my personal health information to carry out treatment and healthcare operations.

Patient (or legally authorized individual) signature _____ Relationship to patient _____ Date _____

Witness _____ Date _____