E. Frank Hancock, DDS
Oral and Maxillofacial Surgery
516 New Market Blvd, Suite 3
Boone, NC 28607
828-264-5711

Release for Doctors and Staff to Discuss Medical Information

I _____, give permission to Dr. Hancock and/or staff to leave medical information:

__regarding appointment dates and times
__regarding test and pathology results
__regarding medications
__all of the above

on my answering machine/voice mail or e-mail, knowing that others may hear or receive the message, especially when I am away from the phone.

Designated Individuals Authorization Form.
Notice of Patient Information Practices Acknowledgement

I hereby authorize one or both of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment, or any administrative operations related to my treatment and payment. I understand that the identity of designated parties must be verified before any information will be released.

Name:_____Relationship:_____
Name:_____Relationship:_____

By signing below, I acknowledge that it is my responsibility to inform Dr. Hancock's Office in writing if I wish to amend these lists in any way.

_____ _____
Printed Patient Name Signature of Witness/Date

_____
Patients Signature *Parent or guardian must sign if patient is under 18.

E. Frank Hancock DDS, DDS, PA

ORAL AND MAXILLOFACIAL SURGERY

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our 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.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

*Protected health information may be disclosed or used for treatment, payment or health care operations.
*The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
*The Practice reserves the right to change the Notice of Privacy Policies.
*The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
*The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
*The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____

-Patient or Representative

Relationship to Patient (if other than patient): _____

Date: ____/___/__

In front of _____

Printed name-Practice Representative