HIPAA Authorization for Disclosure and Obtaining Sensitive Personal Information

I, the Patient, understand that ORAL & MAXILLO FACIAL SURGEONS FOR NORTHERN ILLINOIS, referred to as "the Practice," may use and disclose my protected health information (PHI) as described below:

Purpose of Disclosure:

1. **Treatment:** I understand that my PHI may be used and disclosed to provide, coordinate, or manage my dental and oral health care, including consultation with other healthcare providers as necessary.
2. **Payment:** I authorize the Practice to use and disclose my PHI for billing, claims, and payment activities related to the services provided to me.
3. **Healthcare Operations:** I authorize the Practice to use and disclose my PHI for healthcare operations, including quality improvement activities, staff training, and administrative purposes.
4. **Health Information Exchange (HIE):** I understand that my PHI may be shared electronically with other healthcare providers through Health Information Exchange for the purpose of coordinating my care.

Types of Information to Be Disclosed:

The following types of PHI may be disclosed, as necessary, to achieve the purposes outlined above:

- Dental records and treatment history
- X-rays, images, and diagnostic reports
- Billing and insurance information
- Medical history and medication information

Recipient of Information:

The Practice is authorized to disclose my PHI to the following individuals or entities:

- Healthcare providers involved in my treatment
- Insurance companies for claims and payment purposes
- Business associates providing services on behalf of the Practice
- Health Information Exchange organizations for coordination of care

Expiration and Right to Revoke:

This authorization will remain in effect until I revoke it in writing. I understand that I have the right to revoke this authorization at any time, except to the extent that the Practice has already taken action based on this authorization.

Patient's Rights:

I understand that I have the right to receive a copy of this authorization, and I retain the right to refuse to sign this authorization. My treatment will not be conditioned upon my signing of this authorization, except where required by law.

Contact Information:

If I have any questions or wish to revoke this authorization, I may contact the Practice at the following address:

ORAL & MAXILLO FACIAL SURGEONS FOR NORTHERN ILLINOIS

1675 Bethany Road, Suite A
Sycamore, IL 60178

Tel: 815-895-3000
Fax: 815-895-0505