STONY BROOK
ORAL AND FACIAL SURGERY

Patient Authorization Form

Patient:_____DOB:_____

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request information regarding their care or finances. Under the requirements for HIPAA we are not allowed to give this information to anyone without the patients consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Stony Brook Oral and Facial Surgery to release my records and any information requested to the following individuals.

1._____ Relation to patient: _____
2._____ Relation to patient: _____
3._____ Relation to patient: _____
4._____ Relation to patient: _____

Authorization regarding messages
(Please check all that apply)

___ I authorize you to leave a detailed message on my home or cell number regarding appointments

___ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results, or financial information
___ I authorize you to leave a message with anyone who answers the phone
___ Messages may only be left with_____

Patient signature:_____

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