



**Timothy C. Snyder, DDS, MD**

*Oral & Maxillofacial Surgery*

Diplomate American Board of Oral & Maxillofacial Surgery

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## HIPAA Privacy Consent

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a federal law); our Practice provides this form to comply with HIPAA regulations. 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 (copy available upon request). 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.

Special Request or restrictions:

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Please list names of any other authorized people that may receive information about you: (please list relationship such as parent, spouse, boyfriend, fiancé, sister, etc)

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

By signing below, you confirm your understanding of this HIPAA notice and authorize our office and staff to leave medical information pertaining to your care by the following methods and will assume responsibility to notify our office if this information changes:

Home Telephone, Answering Machine, Work Telephone, Voicemail,  
Facsimile, Cell phone, and or fax or mail medical records to another entity.

Print Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's (or authorized guardian) Signature: \_\_\_\_\_

If an authorized guardian, relationship to patient: \_\_\_\_\_