



CONNECTICUT MAXILLOFACIAL SURGEONS, LLC
HIPAA Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____
Date of Birth: _____

I authorize **Connecticut Maxillofacial Surgeons** to disclose and/or discuss my protected health information with the following individual(s):

Name: _____
Relationship to Patient: _____
Phone Number: _____

Name: _____
Relationship to Patient: _____
Phone Number: _____

Information that may be disclosed:

- Appointment information
- Treatment information
- Billing and insurance information
- All of the above

This authorization allows Connecticut Maxillofacial Surgeons to communicate with the individual(s) listed above regarding my care.

I understand that:

- I may revoke this authorization at any time in writing.
- This authorization will remain in effect unless revoked by me.
- Revocation will not apply to information already disclosed prior to the request.

Patient/Guardian Signature: _____

Printed Name: _____

Date: _____

If signed by personal representative, describe relationship to patient: _____