James F. Nelson, D.D.S.
Michael E. Miller, D.D.S.
Thomas A. Eschenroeder, Sr., D.D.S.
Gregory M. Zoghby, D.D.S.
Jeffrey E. Cyr, D.D.S.
Andrew Ferguson, D.M.D.
Ammar A. Sarraf, D.D.S.
Graham H. Wilson, D.D.S.

Notice of Privacy Practices
Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As provided in our notice, the terms of our notice may change in accordance with Federal regulations. A current copy may be obtained by requesting a copy from our receptionist or calling (804) 354-1600.

You have the right to request that we restrict how Protected Health Information (PHI) about you is used or disclosed. We are not required to agree with this restriction, but if we do we are bound by this agreement. Any request to restrict our use of your information must be done in writing to our practice Privacy Officer.

Commonwealth Oral & Facial Surgery intends to use and disclose the minimum necessary PHI about you for treatment, payment, or health care operations. Other uses and disclosures not described as permitted in our Notice of Privacy Practices will require a current signed and dated authorization from you or your appointed legal representative.

I understand that I may ask questions to Commonwealth Oral & Facial Surgery staff if I do not understand any information contained in the Notice of Privacy Practices.

I, ____, have been provided a copy of the Notice of Privacy Practices for Commonwealth Oral & Facial Surgery.

DISCLOSURES TO FAMILY MEMBERS & FRIENDS

A staff representative of Commonwealth Oral & Facial Surgery (COFS) has explained to me that disclosures may be made to family & friends related to my health or to obtain payment for healthcare services. I understand that COFS will only disclose information relevant to my current treatment.

Check one or the other:

☐ I do not wish to have my healthcare information disclosed to anyone.

☐ I authorize COFS to disclose healthcare information to the following individuals:

NAME	RELATIONSHIP TO PATIENT

Any disclosures made by staff to the above listed individuals will be documented in the patient record in summary format detailing the date of disclosure, the person with whom the information was disclosed to, what information was disclosed, and the name of the employee who disclosed the information.

_______________________________________ ______________________________

Patient Signature or Authorized Representative Date