

Haddon Oral Surgeons, P.A.

Steven J. Garin, D.M.D.

Spec #5277

Jeffrey Litman, D.M.D.

Spec #06706

**HIPAA LAW  
RIGHT TO PRIVACY  
CONSENT**

I GIVE THIS PRACTICE MY CONSENT TO DISCLOSE MY PROTECTED HEALTH INFORMATION IN ORDER TO CARRY OUT MY TREATMENT, TO OBTAIN PAYMENT FROM INSURANCE COMPANIES, AND FOR HEALTH CARE OPERATIONS LIKE QUALITY REVIEWS.

I HAVE BEEN INFORMED THAT I CAN REVIEW THE PRACTICE "NOTICE OF PRIVACY PRACTICES" FOR A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLAIMERS BEFORE SIGNING THIS CONSENT.

I UNDERSTAND THAT THIS PRACTICE HAS THE RIGHT TO CHANGE THEIR PRIVACY PRACTICES AND THAT I MAY OBTAIN ANY REVISED NOTICES AT THE PRACTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST A RESTRICTION ON HOW MY PROTECTED HEALTH INFORMATION IS USED. HOWEVER, I ALSO UNDERSTAND THAT THE PRACTICE IS NOT REQUIRED TO AGREE TO MY REQUEST. IF THE PRACTICE AGREES TO MY REQUESTED RESTRICTION, THEY MUST FOLLOW THE RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, BY MAKING A REQUEST IN WRITING, EXCEPT FOR INFORMATION ALREADY USED OR DISCLOSED.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PRINT NAME \_\_\_\_\_

**OR... SIGNATURE OF PATIENT REPRESENTATIVE AND RELATIONSHIP TO PATIENT  
(IF PATIENT IS UNDER THE AGE OF 18 OR CANNOT SIGN DUE TO LIMITATIONS)**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
PRINT NAME \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_

475 Old Marlton Pike  
Marlton, NJ 08053  
(856) 983-0202  
(856) 983-8990 fax

400 N. Church Street, Suite 140  
Moorestown, NJ 08057  
(856) 722-0101  
(856) 722-9674 fax

25 Jackson Road, Suite C  
Medford, NJ 08055  
(609) 654-2000  
(609) 714-1665 fax

E-Mail : [haddonoral@haddonoral.com](mailto:haddonoral@haddonoral.com)  
Website : [haddonoralsurgeons.com](http://haddonoralsurgeons.com)

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Medical Information Release Form

(HIPAA Release Form)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse \_\_\_\_\_

☐ Child(ren) \_\_\_\_\_

☐ Other \_\_\_\_\_

☐ Information is not to be released to anyone.

This *Release of Information* will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell Number: \_\_\_\_\_

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ \_\_\_\_\_

The best time to reach me is (day) \_\_\_\_\_ between (time) \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_