I. CONSENT FOR THE RELEASE, USE, AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA Release Form)

I, _____, hereby authorize Treasure Coast Oral and Maxillofacial
(Please print patient name)
Surgery, and Drs. Jeffrey M. Brown and Shawn T. Engebretsen, (hereby collectively known as "Practice") to use and/or disclose information contained in my medical records for the purpose of, but not limited to the following: the care and planning of my treatment, communication with health care professionals and/or specialists who may contribute to my care and treatment, and communication with insurance companies for the purpose of obtaining benefits, in accordance with the Notice of Privacy Practices (NOPP), and have had the opportunity to ask any questions. I understand it and do agree to its terms. A copy of the signed, dated consent shall be as effective as the original.

If my medical record should have super-confidential information that could include, HIV/AIDS, alcohol and/or substance abuse diagnosis and treatment records, or psychotherapy records, I specifically authorize Practice to disclose this information verbally or by mail in accordance with the law.

RELEASE OF INFORMATION
I authorize you to release information to the following additional person(s).

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____
Signature of Patient/Parent or Legal Guardian Date

II. ACKNOWLEDGEMENT OF UNDERSTANDING OF POSSIBLE SIDE EFFECTS OF PRESCRIPTIONS

You may possibly be given a medication prescription or multiple prescriptions while under the care of Drs. Brown and/or Engebretsen. All medications have side effects, which may include, but not be limited to: drowsiness, impaired judgment, visual disturbances, nausea, impaired reflexes, etc. It is your responsibility to read the instructions included with the prescriptions, and to ask Dr. Brown or Engebretsen or your Pharmacist if you have any questions. You should not drive or engage in activities that may be affected by these medication side effects. It may result in injury or death to yourself or others. By signing below, you state you understand and will follow these instructions.

_____ _____
Signature of Patient/Parent or Legal Guardian Date