HALF MOON
Oral Maxillofacial & Implant Surgery

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand, that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment for third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

(Please add the names of any individuals you authorize to obtain medical information [including appointment times and locations etc.])

Patient Name_____ Date _____

Patient Signature (or guardian if a minor) _____

Name _____ Relationship to patient _____
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____
Name _____ Relationship to patient _____

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PHOTO AND VIDEO RELEASE FORM

I hereby grant Thomas A. Sarna DDS PLLC absolute and irrevocable rights and unrestricted permission to use photos/.videos taken of me or in which I may be included with other, and to use, reuse, publish and republish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for illustration, promotions, art, editorials,advertising and trade, or any other purpose whatsoever without restriction.

_____
Patient name - Please PRINT

_____ _____
Patient Signature Date
(if under 18 guardian must sign)

AUTORIZACIÓN PARA UTILIZAR MI IMAGEN EN FOTOGRAFÍA O VIDEO

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_____
Nombre del paciente

_____
Fecha: Firma del Padre/Guardian/Paciente: