

Newhall Oral and Maxillofacial Surgery Group

Dr. Landa, Dr. Mizin, Dr. Scaramella, Dr. Marechek

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HIPAA Authorization Form

I authorize my surgeon and/or administrative staff to use the following protected health information, and/or disclose the following protected health information to my insurance company and/or other physician(s) upon request.

Per national standards to protect the privacy of personal health information, we will only release information requested. This pertains to specific dates of service(s), specific laboratory and/or biopsy results. Medical records will not be released to any entity unless authorized by patient or legal guardian.

This authorization shall be in force and effect until the individual in question no longer requires our services for treatment at which time this authorization to use or disclose this protected health information expires.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the receipt and may no longer be protected by federal or state law.

Signature of Patient or Parent/Legal Guardian

Date

Print Name of Patient or Parent/Legal Guardian