Broadway Oral Surgery
136 E. Broadway
Bel Air, MD 21014
(410) 838-6222

I authorize Broadway Oral Surgery to disclose my Protected Health Information (including but not limited to, prescriptions, test results, appointment information and medical records), to the following individuals:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Print Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Witness: _____

Are we permitted to leave results on an answering machine/voicemail? YES _____ NO _____

If **YES** please provide preferred phone number: _____

This form must be updated by the patient annually or whenever there is a change in authorization status.

Broadway Oral and Maxillofacial Surgery

Acknowledgement of Receipt of Notice of Privacy Practices

*** You May Refuse to Sign This Acknowledgment***

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)
