Gulf Coast Oral & Facial Surgery, PA

Patient Disclosure

I _____ understand the HIPAA privacy rule gives individuals the
(Patient/Parent/Guardian)
right to request a restriction on uses and disclosures of their protected health information. I allow Gulf Coast Oral and Facial Surgery, PA, to give my clinical information or answers to questions regarding my care to the below individuals.

AUTHORIZED NAME & CONTACT NUMBERS

1) _____
2) _____
3) _____

Patient's Name: _____
Signature: _____ Date: _____

Medical Consent

I, _____, parent/legal guardian of _____
(Parent/Legal Guardian) (Patient's Name)

do hereby give consent to any medical care/treatment determined by any medical staff of Gulf Coast Oral & Facial Surgery. If the parent or legal guardian(s) are not available, I hereby authorize the names I provide below to make informed medical decisions for the health/welfare of said patient. I also understand it is MY responsibility as parent/legal guardian to provide any/all information necessary to the patient's health/welfare to the below mentioned care seekers, so that the patient receives the best care possible. This includes any proof of insurance, co-pays, and deductibles.

AUTHORIZED NAME & CONTACT NUMBERS

1) _____
2) _____
3) _____

I have read and understand/agree to all policies and procedures of Gulf Coast Oral & Facial Surgery.

Signed: _____
(Parent/Legal Guardian only)
Date: _____ Relationship to the patient: _____