**Authorization to Disclose Health Information**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I authorize the use or disclosure of health information described below from the following individual, office or organization:

**Arthur L. Parker, DMD**

**Priya Mistry, DDS**

**7931 NE Halsey Suite 307**

**Portland, OR 97213**

1. The type and amount of information to be used or disclosed is as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_Entire health record, or any part

\_\_\_\_\_\_\_\_\_\_\_\_\_Entire billing record, or any part

\_\_\_\_\_\_\_\_\_\_\_\_\_Imaging (CT scan)

\_\_\_\_\_\_\_\_\_\_\_\_\_Other information (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. This information may be disclosed to and used by:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Association: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Association: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Association: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the individual, office, or organization address listed above. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contests claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, or condition:

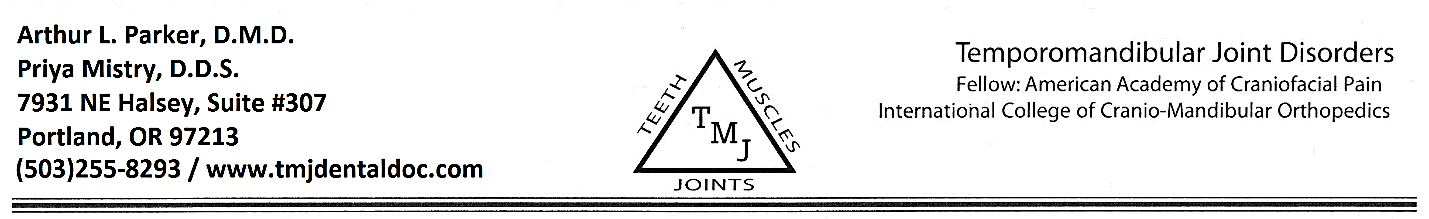
* In six month
* In one year
* In three years
* On this date:\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that information used or disclosed to the authorized individual(s) above may have potential to be subject to unauthorized re-disclosure, and the information may not be protected by HIPAA law and federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office/ organization of: Arthur l. Parker, 7931 NE Halsey #307, Portland, OR 97213, phone: (503)255-8293 or Fax: (503) 252-1214.

**PLEASE NOTE**: Unless otherwise specified by law, we will release only that information which has been created by our employees or agents, including chart notes, lab results, summaries, and consultation reports. Records created by and available from other providers, hospitals, or other care facilities must be obtained directly from other providers or facilities.

Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Consent Form

* A proper diagnosis regarding head and neck pain is very important because serious problems such as vascular disorders, brain tumors, cervical disc disorders, etc., can produce similar symptoms to TMJ disorders. It is important to inform our office of any changes in your health history form that previously provided.
* In order to achieve a successful outcome of your treatment, it is crucial that you make a commitment to keep all scheduled appointment and to remain in treatment until you are medically stationary. It had been our experience that most patients will achieve medical stability in 4-6 months from the time treatment begins.
* Length of treatment may vary according to the complexity of your condition. Treatment times, therefore, may vary from estimation. Although most conditions respond well to treatment, general health, stress, degree of tissue injury, posture, age, work habits, bite relationships, etc., do affect the outcome, and total resolution is not always possible.
* The treatment methods we will use are based on our experience and knowledge to be the most proven, appropriate, cost-effective and conservative. However, you should be aware there is much debate in the medical- dental community regarding the best way to treat various TMJ disorders.
* If an appliance is used in your treatment, it is theoretically possible for the appliance to be swallowed or inhaled. It must be said that a swallowed appliance may have to be surgically removed, and inhaled appliances may lead to respiratory arrest and death.
* As with any medical or dental treatment, unusual occurrences can and do happen. These possibilities could include minor tooth movement, broken or loosen teeth of dental restorations, sore mouth, periodontal problems, muscle spasms, ear pain, neck pain, etc. Any of the mentioned complication are rare, but theoretically may occur. Additional medical and dental risk that have been mentioned may occur.
* You must always bring your splint with you for each and every appointment. Your splint will be re-evaluated in approximately six weeks form the time you receive it, and may require a change in the treatment position at that time.
* Any balance after insurance payments are patient responsibility. Please communicate with the office staff and remit payment when services are rendered. If no payment is received within 60 days, you will be sent to collections and charged a $200 processing fee.

I have read or had read to me the information in this information consent, realized the risk and limitations involved, and consent to treatment. I understand that any of my photographs, models, and x-rays may be used in scientific papers or demonstrations.

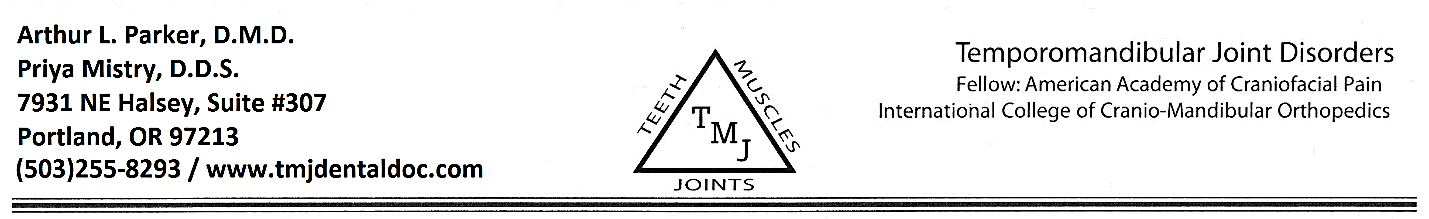
*I also understand that Dr. Arthur l. Parker and Dr. Priya Mistry are not contractual providers with any insurance company.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient and/or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient



HIPAA Consent Form

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 and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices prior* to signing this consent. I understand that this organizations has the right to change its *Notice of Privacy Practices* form time to time and that I may contact organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

Arthur L. Parker, DMD

Priya Mistry, DDS

7931 NE Halsey, Ste. #307

Portland, OR 97213

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and/or health care 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.

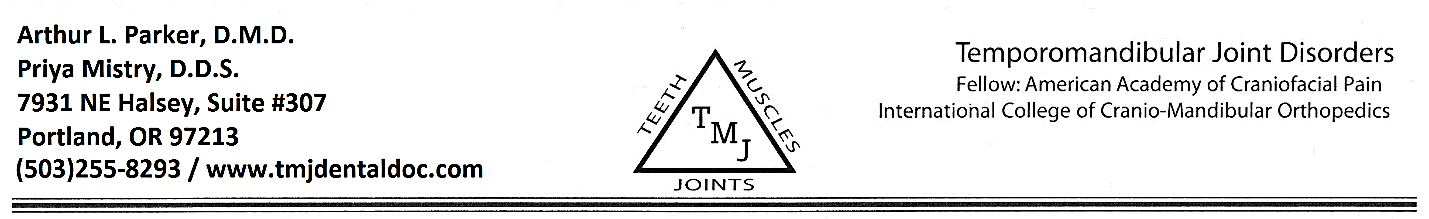
I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this content.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient and/or Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Patient



Sleep Apnea Risk Awareness Survey

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Have you ever had a sleep study done? YES/ NO  If so then when? Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **YES NO** | |
| Do you awaken more than once at night to urinate? ..................................... | \_\_\_\_ \_\_\_\_ | |
| Do you snore? ............................................................................................... | \_\_\_\_ | \_\_\_\_ |
| Does your partner tell you that you stop breathing when you sleep? ........... | \_\_\_\_ | \_\_\_\_ |
| Do you wake up gasping at night? ................................................................ | \_\_\_\_ | \_\_\_\_ |
| Do you feel “worse” when you wake up? ...................................................... | \_\_\_\_ | \_\_\_\_ |
| Do you feel sleepy during the day? .............................................................. | \_\_\_\_ | \_\_\_\_ |
| Do you have high blood pressure? ............................................................... | \_\_\_\_ | \_\_\_\_ |
| Are you more than 30 pounds overweight? .................................................. | \_\_\_\_ | \_\_\_\_ |
| Do you suffer from morning headaches? ...................................................... | \_\_\_\_ | \_\_\_\_ |
| Has your concentration, memory, or temper (irritability) been worsening? | \_\_\_\_ \_\_\_\_ | |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient and/or Legal Guardian Date

