SOUTHWEST ORAL AND MAXILLOFACIAL SURGERY

Jerry L. Jones, M.D., D.D.S.
Diplomate American Board of Oral & Maxillofacial Surgery
Wai Pong Ng, D.M.D.
Diplomate American Board of Oral & Maxillofacial Surgery
Joshua Stone, D.D.S.

(505) 797-3530 • 5900-A Cubero Dr. N.E. • Albuquerque, NM 87109

PATIENT HIPAA Awareness

With my permission, Dr. Jerry Jones, Dr. Wai Pong Ng and Dr. Joshua Stone may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Jerry Jones, Dr. Wai Pong Ng and Dr. Joshua Stone reserve the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our office.

With my permission, the office of Dr. Jerry Jones, Dr. Wai Pong Ng and Dr. Joshua Stone may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying our TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Jerry Jones, Dr. Wai Pong Ng and Dr. Joshua Stone may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that Dr. Jerry Jones, Dr. Wai Pong Ng and Dr. Joshua Stone restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Dr. Jerry Jones, Dr. Wai Pong Ng and Dr. Joshua Stone to use and disclose my PHI for TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Patient or Legal Guardian Date

Patient Name