JOSEPH F. FINELLI, JR., D.D.S., P.C.
DANIELLE M. CUNNINGHAM, D.D.S.

PRACTICE LIMITED TO ORAL AND MAXILLOFACIAL SURGERY

5109 WEST GENESEE STREET
CAMILLUS, NEW YORK 13031
315/487-2668

According to New York State Law, we are now required to electronically transmit all prescriptions directly to your pharmacy. In order for us to be able to do this, we must have the following information:

Please fill out the name and phone number of your pharmacy below.

Pharmacy Name: _____
Pharmacy Address: _____
Pharmacy Phone #: _____

Gender: M or F

Date of Birth: _____

Any Drug Allergies? Y or N
Please List: _____

Other Allergies? _____

Do you require your medication to be in liquid form? Y or N

Patients Signature: _____

If patient is a minor, parent/guardian please sign here:

_____

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Patient Name: _____

If patient is under the age of 18, parent / guardian name as well.

_____

I have been presented with the HIPAA Notice of Privacy Practices and I authorize the following individuals to have access to my "Protected Health Information".

_____ _____

_____ _____

I also authorize Dr.'s Finelli and Cunningham's office to be able to leave messages for appointments or other medical information on:

	Appointment Information	Medical Information
1) Answering Machine?	Yes / No	Yes / No
2) Cell phone?	Yes / No	Yes / No
3) Office voicemail?	Yes / No	Yes / No
4) Persons listed above?	Yes / No	Yes / No
5) Mail information?	Yes / No	Yes / No
6) E-mail information?	Yes / No	Yes / No

***I consent to have the practice use and disclose my protected health information for payment, treatment and health care operations purposes, and for such other purposes that are permitted under HIPAA or other federal or state law without my written authorization.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law limits this possibility.

* I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature: _____ Date Signed: _____