WALNUT HILL COSMETIC & FAMILY DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

_____
Please print your name here

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____

_____

_____

_____ _____

Employee Signature Date

HIPPA Consent for Use / Disclosure of Health Information
This form does not constitute legal advice and covers only federal, not state, laws.

WALNUT HILL COSMETIC & FAMILY DENTISTRY
CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our **Notice of Privacy Practices**, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

_____

Patient's Signature or Signature of Patient's Representative Date

_____

Printed Name of Patient's Representative Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Olubukola Onimisi, DDS

Practice Address: Walnut Hill Cosmetic & Family Dentistry 2679 Walnut Hill Lane Dallas, TX 75229
Phone: 214- 352- 3668 Fax: 214- 351- 5829
E-Mail: onimisi@walnuthilldental.com

WALNUT HILL COSMETIC & FAMILY DENTISTRY E-MAIL/ TEXT RELEASE FORM

Date: _____

I _____ wish to communicate with Walnut Hill Cosmetic & Family Dentistry on matters related to my health and my medical/ dental treatments:

Via E-mail Communication	Yes □ No □
Via Text Messages Communication	Yes □ No □

Name of Patient: _____

Signature: _____

Witness Name: _____ Signature: _____

Date: _____

HIPAA E-Mail Release Form
Before sending any non-encrypted e-mail communications (including attachments) containing Protected Health Information to any recipient, ensure that this Form has been signed and is on file. Provide a copy to the Patient.
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