ORAL SURGERY ASSOCIATES

R. Brent Bailey, D.D.S. Michael J. Anton, D.D.S. Garett J. Seeba, D.M.D., M.D.
595 E. Medical Center Boulevard Webster, TX 77598 (281) 461-1982

PATIENT: _____ **DATE:** _____

A. *NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT:*

I, _____, acknowledge that I have been given a copy of Oral
Printed name of patient or patient representative

Surgery Associates' Notice of Privacy Practices. _____
Signature of patient or patient's representative

_____
Relationship to Patient (if other than patient)

B. *PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:*

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Policies
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon the execution of this Consent.

Consent was signed by: _____ _____
Printed name of patient or patient representative Signature of patient or patient's representative

_____
Relationship to Patient (if other than patient)

Restrictions: _____

_____

Email and Text Consent

Patient Name:_____

We may use and disclose medical information to contact you as a reminder that you have an appointment for dental care with the practice, rate your most recent office visit, or that you are due to receive periodic care from the practice. This contact may be by phone, in writing, email, or otherwise and may involve the leaving of an email, message on an answering machine, text message or otherwise, which could potentially be received or intercepted by others.

- ☐ I give my permission to the office of Oral Surgery Associates to contact me through telephone or email.
- ☐ I do not give my permission to the office of Oral Surgery Associates to contact me through telephone or email.

_____ _____

Patient's (or Legal Guardian's) Signature Date