PATIENT PHOTO / HIPPA FORM

WEB, SOCIAL MEDIA, & PHOTO RELEASE FORM

1601 E. Debbie Lane Ste# 1125, Mansfield, TX 76063

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described below.

Description of the specific information to be used or disclosed;

- Photographs and/or video of dental treatments

Person/entity requesting the information and authorized to make the requested use or disclosure:

- Doctor, Manager, and Staff of **Mansfield Dental Center**

This information is being requested for the following purpose(s): Patient & Employee Education, Promotion, Marketing, Prints or Ads.

This authorization shall remain in effect from the date signed below until **01/01/2050** (expiration date or event). Upon expiration of this authorization, **Mansfield Dental Center** will not permit further release of any photography or information, but will not be able to call back any photography or information already released.

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office at the address above, Attention: Privacy Officer. Upon revoking of this authorization, **Mansfield Dental Center** will not permit further release of any photography or information, but will not be able to call back any photography or information already released.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPPA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

I (the patient), grant my permission to Mansfield Dental Center to have my dental work and/or photographs posted within their dental practice and/or on their website, social media accounts, video, or slide show presentations, print ads, and all other marketing or advertising efforts that promote their dental practice.

Patient/Parent/Guardian signature: _____ Date: _____
(Over 18 years or older to sign)

HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgment & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FURTURE.**

Please ***print*** name of patient: _____ ***Signature*** of patient or Guardian: _____

Legal Representative / Guardian: _____ Relationship of Legal Representative / Guardian: _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOVLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEATLH INFORMATION: (This includes step parents, grandparents, and or any care takers who can have access to this patients records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In signing this HIPPA patient acknowledgement form, you acknowledge, and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus rue Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patients (or representatives) signature on this acknowledgement but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because: _____
- ☐ Other (please describe): _____

Signature of Office: _____ Date: _____