Whole Body Dental
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HIPAA Notice of Privacy Acceptance

I _____have reviewed the Notice of Privacy Practices.

Signature: _____ Date: _____

Consent to Leave a Message

We at Whole Body Dental are working to ensure that confidentiality regarding your protected health information and care is maintained at all times. Due to confidentiality concerns and to comply with the HIPAA act of 1996, we need your signature to allow us to leave a message about your upcoming office visit, account information, and/or any results you may want us to convey to you via telephone or electronic messaging.

I _____ give Whole Body Dental permission to:

Leave a message regarding my upcoming visit, account information, and test results on my answering machine: YES ☐/ NO☐

Leave a message with someone who answers the phone at my residence: YES ☐/ NO☐

Leave a message at my place of employment: YES☐ / NO☐

Person(s) you wish to have your personal information shared/discussed with:

_____

Signature: _____ Date: _____