HIPAA Receipt/Consent

_____

(Last Name) *please print* (First Name) (M.I)

I agree that the practice may communicate with me electronically at the following email address:

_____

(E-mail Address) *please print*

I consent to receive calls and/or text messages related to my protected dental services at the phone number(s) below, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____

Phone Number

Do we have permission to:

Send appointment reminders to the phone number provided above? Yes_____ No_____

Leave appointment, billing or dental information
on your answering machine/voice-mail/e-mail? Yes_____ No_____

I authorize the release of information including the diagnosis, x-rays/CT scan, billing, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)(must be 18+)_____
[ ] Other (General Dentist)_____
[ ] Information is not to be released to anyone.
This Release of Information will remain in effect until terminated by me in writing.

I give permission to share my appointment, billing or dental information with the person(s) named above:

_____ _____

Signature of Patient, Parent or Guardian Date

If signed by other than patient, please specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have read/ or received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient, Parent or Guardian Date

If signed by other than patient, please specify relationship to patient: _____