HIPAA COMPLIANCE

Patient Consent to Receive Mail and/or Telephone Messages

Name of Patient: (Please print)

_____

LAST FIRST MIDDLE

1. Do we have your permission to send recall/treatment appointment reminders to your home? Yes ____ No ____

2. Do we have your permission to leave the following information on your home answering machine or voicemail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

3. Do we have your permission to leave the following information on your work answering machine or voicemail?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

4. Do we have your permission to send the following information to your e-mail address provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

5. Do we have your permission to leave the following information on your cell phone, voicemail, or via text message to the number provided on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

6. Do we have your permission to send the following information to your fax machine at the number provided to us on your patient registration form?

Appointment Information	Yes ____	No ____
Billing Information	Yes ____	No ____
Dental/Medical Information	Yes ____	No ____

7. I hereby give permission to share any information concerning me with the person(s) named below:

_____ _____

Name Name

Date: _____

Signature: _____ Witness: _____

Print Name: _____ Print Name: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Legal Guardian ☐ Other: _____