Communication Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These Rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my Protected Health Information to carry out:

- Text messages containing appointment confirmations with date/time, offers to schedule on offered date/time, requests for payment with amount due and link to pay online, or requests to contact office.
- Emails containing appointment confirmations with date/time, offers to schedule on offered date/time, or account correspondence including requests for payment with amount due and link to pay online.
- Mailed reminder cards for scheduled or missed hygiene appointments with date/time.

Emergency contacts:

_____
Name

_____
Phone

_____
Relationship

Can we leave a message with this person? Yes or No

Can we discuss treatment with this person? Yes or No

Can we discuss account information with this person? Yes or No

_____
Name

_____
Phone

_____
Relationship

Can we leave a message with this person? Yes or No

Can we discuss treatment with this person? Yes or No

Can we discuss account information with this person? Yes or No

Patient or Legal Representative Signature

_____
Signature of patient or legal representative Date

_____
Printed name of legal representative

_____
Relationship to patient

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient indicated above.

_____
Signature of patient or legal representative Date