

## HIPAA PATIENT CONSENT FORM

Patient Name (please print) \_\_\_\_\_

1) You have my consent to call my home and leave a message on the answering machine or with a family member in regard to an appointment I may need.

Yes \_\_\_\_\_ No \_\_\_\_\_

2) You have my consent to call my place of employment and to leave a message on my voice mail or with a co-worker to confirm an appointment or to ask for me to call the office. We will at no time share any personal information regarding your treatment or our reason for calling other than to confirm an existing appointment.

Yes \_\_\_\_\_ No \_\_\_\_\_

3) You have my consent to send me a reminder post card for an upcoming appointment with the hygienist or as a reminder that I am overdue for a checkup.

Yes \_\_\_\_\_ No \_\_\_\_\_

Patient Signature \_\_\_\_\_

Patient SS# \_\_\_\_\_

Effective Date \_\_\_\_\_