



Cascade Family & Implant Dentistry

Patient Acknowledgement/Consent

I consent to your disclosure of my information, which you deem necessary in connection with my treatment.

Patient Name (Please print)

Patient Signature (Parent sign if minor)

Date

HIPAA prevents us from disclosing any information about you to anyone (other than your medical and dental providers) without your permission.

To whom may we release information regarding your treatment?

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

In accordance with HIPAA guidelines, we must have permission to call/text you and/or leave a message. Please provide your email and cell phone so we may contact you regarding your dental care and treatment.

Cell phone

Email

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement

An emergency situation prevented the patient from signing the Acknowledgement

Office personnel (signature)

Office Personnel (print name)

Date: _____