
# PATIENT CONSENT TO RECEIVE MAIL, E-mail &/Or TELEPHONE MESSAGES

_____

Name of Patient's parent or legal guardian Signature

_____

Email Address (please print)

Do we have your permission to:
Send a recall appointment reminder to your home? Yes No
Leave appointment, billing or dental information
on Your answering machine/voice mail/email: Yes No

I give permission to share appointment, billing or dental information with the person named below:
Name: _____

_____

Signature of Patient's parent or legal guardian Date

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

***You May Refuse to Sign This Acknowledgement***

I._____, heave received a copy of this office's Notice of Privacy Practices.

_____

Print Name Relation to the Patient(s)

_____

Signature Date

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of out Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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