HIPAA COMMUNICATION AUTHORIZATION

PATIENT NAME(S) ____

I, ________________________ on _______________(date) give Vernon Pediatric Dentistry permission to contact me regarding appointments or patient information in the following manner.

Home phone: Y /N Can we leave a voice message? Y / N

Cell Phone: Y /N Can we leave a text message Y/ N Voice Mail Y/ N

Email: Y /N (If **"yes", please provide email address**)

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Written Communication: May we send appointment reminders, financial requirement updates? Y / N

PLEASE LIST BELOW ANY PERSON WHO MAY BE BRINGING YOUR CHILD TO APPOINTMENTS **OTHER THAN A PARENT**

Please include all Grand Parents, other relatives and caregivers such as Nannies or Daycare providers.

_______________________________ Relationship to patient ____________

_______________________________ Relationship to patient ____________

_______________________________ Relationship to patient ____________

May we communicate financial information with the above listed person(s)? This would include fees due at time of service, previous balances or fees for future treatment. Y/ N If No please specify. ___________________________

Please provide the BEST contact # to reach you if needed _________________

Parent /Guardian Signature ____________________________ Date______