Patient Consent to receive Mail and/or Telephone Messages

Please Print (Last Name) (First Name) (M.I.)

Do we have your permission to:

Send a recall appointment reminder to your home? Y____N___

Leave appointment, billing or dental information on your answering machine or voice/email Y____ N___

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

Name:_____

_____ _____
Signature of Patient/Parent or Legal Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of April 14, 2003.

_____ _____
Signature of Patient/Parent or Legal Guardian Date