PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

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Please Print (Last Name) (First Name) (MI)

Do we have your permission to:

1. Send a dental appointment postcard to your home? Y_____ N_____ 
2. Leave appointment, billing or dental information on your answering machine, voicemail or email? Y_____ N_____ 

I give permission to share my appointment, billing or dental information with the following individual(s):

________________________________________________________________________

________________________________________________________________________

Signature of patient/parent/legal guardian ____________________________ Date __________

Acknowledgement of Receipt of Notice of Privacy Practices

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

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Signature of patient/parent/legal guardian ____________________________ Date __________