HIPPA ACKNOWLEDGEMENT

I understand that I may inspect or copy the protected health information described by this by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form.

Patient Name: _____

___ By checking here, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

___ You may contact me on my mobile number.

___ You may text me.

___ You may send me an email.

___ You may contact me on my home phone number.

Please list authorized person with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

_____

_____

___ By checking here, I understand that the above information and agree with its contents, and this will serve as my electronic signature for HIPPA Disclosure Form.

Name of person completing this form:

_____