Authorization to Call or Leave Messages

In accordance with HIPAA regulations, we are requesting, in writing, the best phone number(s) and/or e-mail we may use to contact you and/or to leave a message. Most calls will be regarding scheduling, however, on occasion we may call regarding your oral health or your account.

Please provide only those phone numbers and e-mail that we have permission to leave sensitive information.

(Please print clearly—Thank you)

Patient Name:

_____

Parent/Guardian/Personal Agent: _____
(For patients under the age of 18)

Home #: _____
Work #: _____
Cell #: _____
E-mail: _____

The best way to reach me in case of last-minute scheduling changes or other reasons: ( ) Home; ( ) Work; ( ) Cell; ( ) e-mail *(check all that apply)*

Patient's Authorization to Release Information

I, _____, authorize **Dr. Evanson and staff** to share and/or release dental information to _____ .

Relationship: _____
Home #: _____
Work #: _____
Cell #: _____

I understand that I may remove this authorization at any time in writing.

Signature of Patient:_____
Date:_____

Parent or Guardian Signature _____
Date_____

This authorization will be kept in your chart for future reference. No changes will be made unless authorized by you in writing.
If you wish to make any changes please request another form.
Thank you.