

We are sorry to burden you with so much paperwork; however, the privacy regulations passed by the federal government require that we abide by your wishes on the following:

Name: _____

Home Phone: _____ **Cell Phone:** _____

Can we leave messages/detailed information regarding your dental information on voicemail or answering machine at either of these phone numbers? Yes No

Specifics: _____

To whom, other than yourself, may we speak regarding your Dental Information?

List Names(s): _____

Your Work Phone: _____ **Extension:** _____

Can we leave messages/detailed information regarding your dental information on voicemail or answering machine at this number: Yes No

Specifics: _____

Your E-Mail Address: _____

Can we leave messages/detailed information regarding your dental information at this address: Yes No

Specifics: _____

Should any BILLING ISSUES arise, do you give anyone else permission to act on your behalf?

Yes No If yes, please name: _____ Relationship _____

We are required by law to maintain the privacy of protected health information, and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. If you have any questions, please speak with our HIPPA Compliance Officer in person or by phone at our main number.

I hereby give permission to discuss my health and or billing information with the above. I have received a copy of the Notice of Privacy Practices. I have the right to withdraw or revise my permission at any time, in writing.

My signature below authorizes release of dental information to my insurance carrier, if applicable, for determination of dental services provided to my by Dr. Ronald L Damore, DDS. This authorization remains in effect until revoked.

Patient Signature

Date