HIPAA- Patient Consent of Information

The Grove Family Dentistry, to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the dentist and staff of The Grove Family Dentistry from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing The Grove Family Dentistry and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Practice Name physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply)

_____ on an answering machine or voicemail at home or cell phone
_____ on an answering machine or voicemail at work
_____ with _____ relationship _____
with _____ relationship _____
with _____ relationship _____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature (or Guardian) Date

_____ _____
Witness Date

HIPAA – Notice of Privacy Practice Acknowledgement

____ I have been provided a copy of Practice Name Privacy Practice.
____ I have declined a copy of Practice Name Notice of Privacy Practice.

_____ _____
Patient's Signature Date

** You May Refuse to Sign This Acknowledgement **