

Canyon Falls Dental PLLC

HIPAA - Patient Consent of Information

Canyon Falls Dental PLLC, in order 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 physicians and staff of Canyon Falls Dental 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 Canyon Falls Dental PLLC physicians 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 Canyon Falls Dental PLLC physicians and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary (check all that apply):

via text message
 on an answering machine or voicemail at home or cell phone
 on an answering machine or voicemail at work
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/ Parent or Guardian's Signature

Date

Witness

Date

HIPAA – Notice of Privacy Practice Acknowledgement

I have been provided a copy of Canyon Falls Dental's Notice of Privacy Practice.

I have declined a copy of Canyon Falls Dental's Notice of Privacy Practice.

Patient's/ Parent or Guardian's Signature

Date