New Brighton Family Dentistry

PATIENT COMMUNICATION FORM

A. **Family and Friends**. **It is the office policy of New Brighton Family Dentistry NOT to release confidential medical information regarding your treatment to anyone, except for:**

- parent/legal guardian
- other persons authorized by the patient
- as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the room, we will assume, unless you object, that that person may receive information regarding your treatment)
- in emergency situations or
- as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you anticipate that you will need or want medical or financial information to be provided to family members, friends, or caretakers/babysitters, please put their name(s) below, so that we may best serve you. Be sure to circle what information you want or do not want shared. For example, if you want only medical information to be shared with Aunt Ruth, be sure to indicate "yes" for Health Care Information and "no" for Financial Information.

	Health Care Information	**Financial Information**
Spouse: ____________________________________	Yes No	Yes No
Parent: ____________________________________	Yes No	Yes No
Other: ____________________________________	Yes No	Yes No
____________________________________	Yes No	Yes No
____________________________________	Yes No	Yes No

B. **Communications. Please tell us if these ways to contact you are acceptable or not and if we can leave a message:**

			OK to leave message?
• Home phone	Yes No	If yes, please give number to use:________________	Yes No
• Cell phone	Yes No	If yes, please give number to use:________________	Yes No
• Work phone	Yes No	If yes, please give number to use:________________	Yes No
• Text	Yes No	If yes, please give number to use:________________	Yes No
• Email	Yes No	If yes, please give email address to use:____________________________	
• Traditional mail	Yes No		

By signing below, you authorize that the above named people may/may not receive information regarding your care and finances **AND** you indicate how we may/may not contact you. **NOTE**: If you wish to cancel or change this agreement, please inform our office in person, in writing or by calling our office. This authorization may be cancelled to the extent allowed by law. If you do cancel this authorization, you understand that New Brighton Family Dentistry may have already released information about you after you gave your original permission.

PRINTED NAME____

Patient or Parent/Guardian Signature:____Date: _____________________

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FOR OFFICE USE

Changes to above, authorized by patient by phone, mail or in person:

Change	Date	Staff Initials
____	________	_______
____	________	_______
____	________	_______
____	________	_______
____	________	_______