HIPPA RELEASE FOR PROTECTED HEALTH INFORMATION

I,____, give Barrett Davis, Jr. DDS, permission to speak to the following people regarding my health status, including diagnosis, treatment options and plans and payment for dental services I receive from Barrett Davis, Jr. DDS.

This consent is valid until such time as I provide Barrett Davis, Jr. DDS written revocation of it.

Barrett Davis, Jr. DDS may speak with:

Name:____ Phone number: ____________________

Relationship:_______________________________________

Name:____ Phone number: ____________________

Relationship:_______________________________________

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Dr. Barrett Davis' **Notice of Privacy Policies** (copies available upon request), detailing how my information may be used and disclosed as permitted under federal and state law, I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical/dental information.

RESTRICTIONS

May we call you at work? Yes____ No____
Leave a message on your answering machine? Yes____ No____
Call on a cell phone? Yes____ No____
Text an appointment reminder?* Yes____ No____
Send an appointment reminder by e-mail?* Yes____ No____

Cell phone number ____

E-mail address____

*For **email and/or text communication**, I understand that this information is **NOT** sent in an encrypted manner and there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ **Photo Consent**: Occasionally we take photos of our patients. Common examples are photos of children with no cavities for our "No Cavity Club" and before/after photos of cosmetic cases. By checking this box you are giving us permission to post these photos in our office and on our website/Facebook page.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

Patient signature: ____ Date _________________