Contact and Information Release Form

Please provide us with the information listed below to allow us to comply with HIPAA regulations in regards to contacting you and releasing protected health information (PHI) to others. This will include, but not limited to, appointment reminders, treatment, conditions, financial records, referrals, and billing.

Patient Name:______________________________ DOB:________________

Initial *the contact below that you wish to be used:*

______Home Phone ________Cell Phone ________Work Phone

Email:____

______ I wish to be contacted via text messages to remind me about upcoming appointments and the need for future appointments.

I authorize personal and/or voice messages to be left at the following numbers regarding appointment times/dates or need for appointments.

______Home Phone ________Cell Phone ________Work Phone

The following persons listed below may be contacted regarding my personal health information as listed above:

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By signing below you agree to allow Rocky Top Dentistry and its employees to contact you and release your PHI as listed above. Any changes must be submitted in writing to our office. Rocky Top Dentistry and its representatives *will not* be held liable for information released in error due to changes not received in writing.

Signature:_______________________________________

Date:_________________