Eden Family Dentistry

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Consent to leave Phone Message/Release of Information

Dear patient:

We have adopted a policy that requires our staff to obtain authorization from the patient to release and/or leave a detailed message for the patient. Secondary to the new HIPPA guidelines, we need to guard against violating any patient confidentiality and protect our staff. If we do not have a signed consent on file, we may only leave our name and phone number on a voicemail asking you to call back.

By completing the consent below you authorize us to release information or leave a detailed message on voicemail or with specific individual.

I give my consent below you authorize us to release information or leave a detailed message on voicemail or with a specific individual.

(PLEASE CHECK ALL THAT APPLY):

☐ May leave detailed message on voicemail at home#:_____

☐ May leave detailed message on voicemail at work#:_____

☐ May leave detailed message on mobile phone #:_____

☐ May leave information with spouse (name & number):_____

☐ May leave detailed message on different phone#:_____

☐ May leave information with other family member (name &

relationship):_____

☐ May correspond via email (email address):_____

☐ **DO NOT leave any detailed message on phone or emails. PLEASE contact me directly.**

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

_____ _____

Patient Signature Date