Patient Name: _____ Date:_____

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operation:

NAME(s)

- ☐ **SPOUSE** _____
- ☐ **CHILDREN** _____
- ☐ **RELATIVES** _____
- ☐ **FRIENDS/CAREGIVERS** _____
- ☐ **OTHERS** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (June 18, 2019 Notice)

I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity, i.e. referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

I fully understand and accept the information on this consent.

_____ _____

Patient/Guardian Signature **Print name of person signing**

*If you are not the patient signing; are you the legal guardian, custodian or have ***Power of Attorney*** for the patient, for treatment, payment or healthcare operations. **Yes** ☐ **No** ☐

Electronic Communication Agreement

I agree that Knellinger Dental Excellence may communicate with me using the following electronic methods:

☐ Text

☐ Email (Please Print): _____

By signing below I agree to the following:

- I am aware that there is some level of risk that third parties might be able to read unencrypted emails.
- I am responsible for providing the dental practice any updates to my email address.
- I understand that Knellinger Dental Excellence will **not** sell or disclose any HIPAA protected personal contact information to any third party for marketing purposes without my expressed written permission.
- I can withdraw my consent to electronic communications at any time by calling: **(727) 785-3383**

Patient Signature:_____

FOR OFFICE USE ONLY FOR OFFICE USE ONLY FOR OFFICE USE ONLY FOR OFFICE USE ONLY

{ } CONSENT FORM received and reviewed by _____

{ } CONSENT FORM placed in the patient's medical record on _____