ESSENTIAL DENTAL CARE

Patient Privacy Directive

In our effort to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle your response to the following:

May we leave messages on a voice mail at home or on your cell phone to discuss appointments or treatments? **Yes No N/A**

May we leave messages with or discuss your appointments/treatment with your spouse?

Yes No N/A

If you are over the age of 18, may we discuss your appointments/treatment with your children?

Yes No N/A

Indicate with a check mark the best form of communication and email address or numbers where we may call/text you to talk to you or leave a voice messages:

Home_____	_____call to talk	___leave voice message
Cell _____	_____**call** to talk ____**text**	___leave voice message
Office _____	_____call to talk	___leave voice message

You must inform us, in writing, of any changes in your directives. This record takes effect upon signing and dating this form. It will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.

I acknowledge I have received a copy of the "Notice of Privacy Practices"

Signature: _____ Date: _____

Printed Name: _____

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