HIPAA COMMUNICATION FORM

Patient Name: _____

Patient privacy is important at Professional Dental Alliance (dba-Refresh Dental). Our policy to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide us with information with whom we can communicate with concerning your care. We would also like to obtain information regarding alternative communication preferences so that we know the best way to contact you with appointment reminders or other information related to your care.

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

You are free to make changes to your preferences at any time. Updates must be made in person and a new form completed.

Please provide the names and relationship to patient for those individuals you will need or want your health information to be provided. This includes family members, friends, organizations or caregivers/babysitters:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

***Patient Communication* –** Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other information via text message, email or via phone. Limited information will be left when leaving a voice massage. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer we use an additional communication preference for appointment reminders or other information related to your care.

Patient Name:_____ Relationship to Patient_____

Parent/Guardian Signature:_____ Date:_____