



**HIPAA
Patient Consent of Information**

Patient's Name

Date of Birth

Glacier Peak Dentistry, in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect the dentists and staff of Glacier Peak Dentistry from violating the patient's confidentiality. If there is not a signed consent on file, physicians and staff will only leave their name and telephone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return the call.

By completing the consent below, you are allowing Glacier Peak Dentistry dentists and its staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

I give my consent to Glacier Peak Dentistry dentists and staff to leave a message regarding scheduling, treatment, surgery, lab or radiology results, or other information as necessary. (Check all that apply)

_____ on an answering machine or voicemail at home or cell phone

_____ on an answering machine or voicemail at work

_____ with _____ relationship _____

_____ with _____ relationship _____

_____ I do not consent to messages being left at home, work or with any other person. I wish to be contacted directly

Patient's or Guardian's Signature

Date

Witness' Signature

Date

HIPAA – Notice of Privacy Practice Acknowledgement

_____ I have been provided a copy of Glacier Peak Dentistry Privacy Practice

_____ I have declined a copy of Glacier Peak Dentistry Notice of Privacy Practice

Patient's or Guardian's Signature

Date