CONSENT FOR LEAVING MESSAGES

CONSENT TO LEAVE MESSAGES AND SHARE INFORMATION WITH FAMILY/FRIENDS

I understand that my healthcare information at **Lakeview Dental** is protected and I have received a copy of their **"NOTICE OF PRIVACY PRACTICES".**

In order for **Lakeview Dental** to leave detailed messages on my voice mail, I need to give my permission for them to do so.

CONSENT FOR LEAVING MESSAGES

( ) I consent to information regarding mine or my minor child's detailed dental appointment be left on voice mail. I understand that **"sensitive"** information as noted below will be excluded.

CONSENT FOR SHARED INFORMATION WITH FAMILY MEMBERS & FRIENDS

( ) I wish family members or friends to have access to my health information. The name (s) listed below are family members or friends to whom I grant access to my health care information. I will rely on the professional judgment of my provider and his designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussion and that **NO** paper copies of my protected health care information will be provided without my signature on a **"release of information"** form.

I understand that some information is considered "sensitive" I understand that I must check the specific boxes in order for my provider or his designee to release any "sensitive" information.

( ) Mental Health/psychiatric disorder ( ) Chemical Dependency ( ) Pregnancy ( ) HIV/ AIDS

Name 1) _____ relationship_____

2) _____ relationship _____

3) _____ relationship _____

Print Patient Name _____

Signature _____ Date _____