Authorization for disclosure of protected Health Information

I hereby authorize **Alternative Dental P.C.** and staff to contact me with the appointment time, recall visits and other protected health information in the following matter:

E-Mail _____

All emails are protected and will be coming from HIPPA compliant platform and will not have any soliciting information. E-mail must be provided for confirmation purposes and EOB from your Insurance Company.

Home Telephone # _____ Answering Machine
- Yes No

Cell Telephone # _____ Answering Machine
- Yes No

Work Telephone # _____ Answering Machine
- Yes No

PREFFERED METHOD OF Appointment CONFIRMATION BESIDES PHONE CALL

☐ **TEXT MESSAGE: Phone #** _____

☐ **E-MAIL**

Other Persons authorized to receive my information:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Patient name (print):_____ Date of birth:_____

Signature: _____ Date:_____