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PRACTICE LIMITED TO PERIODONTICS

DIPLOMATE AMERICAN BOARD OF PERIODONTOLOGY

AUTHORIZATION TO COMMUNICATE

METHOD	USE PATIENT ID	OK TO LEAVE VOICEMAIL	OK TO LEAVE MESSAGE WITH ANOTHER PERSON	PREFERRED CONTACT METHOD(S)	BEST TIME TO CALL *
Call Work Phone	___Yes ___No	___Yes ___No	___Yes ___No	☐	
Call Cell Phone	___Yes ___No	___Yes ___No	___Yes ___No	☐	
Call Home Phone	___Yes ___No	___Yes ___No	___Yes ___No	☐	
Send Email				☐	
	☐ Email Appointment Reminders				
	☐ Email Medical Information				
	☐ Email Marketing Information				
Send Regular Mail	___Yes ___No			☐	
Mail to which Address:		☐ Home	☐ Other (please list below)		
Send Text				☐	
	☐ Text Appt Reminders – if so, list cell carrier:				
	☐ Text Marketing Information – if so, list cell carrier:				

* Best Time to Call Examples: Morning, Afternoon, Daytime, Evening, Emergency Only, Do not Call, or Do Not Leave Message

If it is OK to leave a message with another person, please list them:

Name	PHONE #	Relationship	OK to Release Results	Any Comments
			___Yes ___No	
			___Yes ___No	
			___Yes ___No	

The purpose of this authorization is to meet the patient's request for information disclosures and uses. This authorization shall be enforced until revoked by the patient (in writing).

This practice will verify the identity of any entity requesting protected health information.

Rights of the Patient
I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed at the top of this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____ _____
Signature of Patient or Personal Representative (attach necessary documentation) Date

Receiving Employee _____ Date _____

- **Copy given to patient**