

**STOCKBRIDGE MUNSEE DENTAL CLINIC
PRIVACY CONTACT FORM**

Patient Name: _____ DOB: _____
Phone: _____ Chart #: _____

Contact Permission- In the event that we need to contact you for matters including, but not limited to, dental treatment, appointment reminders, follow up or answers to questions. Stockbridge Munsee Dental Clinic will attempt to reach you by the method you specify. How may we contact you?

<p>Phone Yes No</p> <p>Work# _____</p> <p>Home# _____</p> <p>Cell# _____</p>	<p>Mail Yes No</p> <p>Address: _____</p> <p>_____</p> <p>_____</p>
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May we identify ourselves as being from your dentist's office?

At home? Yes No

At work? Yes No

May we leave a voicemail or answering machine message?

At home? Yes No

At work? Yes No

May we leave a message with a family member? Yes No

If yes, please identify in the next section.

Consent to Access of Protected Dental Information- The following are representatives to whom Stockbridge Munsee Dental Clinic is permitted to disclose your protected dental information. The disclosures may include, but are not limited to, dental treatment information, reminders, follow up or answers to questions.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Restriction on Consent- Please indicate any restrictions you may have on the nature of the disclosures to be made to these representatives: _____

I agree, that by signing this form, I am giving my consent for the Stockbridge Munsee Dental Clinic to contact me in the manner described above, and to disclose my protected dental information to the representatives identified above. I have the right to revoke this consent at anytime by giving a written notice of revocation.

Printed Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Witnessed by: _____ Date: _____