Communication Consent Form

Name of patient: _____ Date of Birth: _____

Zöe Dental is authorized to release protected health information about the above named patient in the following manner and/or to selected persons.

Check each person/entity approved to receive information.	Check type of information that can be given to person/entity on the left in the same section.
☐ Voicemail	☐ Appointments/Reminders to Schedule ☐ Treatment ☐ Financial
☐ Other person(s) (provide name and number): • _____ • _____	☐ Appointments/Reminders to Schedule ☐ Treatment ☐ Financial
☐ Email communication (provide email address): • _____ *For email communication to occur, accept the disclosure below	☐ Appointments/Reminders to Schedule ☐ Treatment ☐ Financial ☐ Personal (birthday, holiday, gratitude, etc.) ☐ Breach notification
☐ Text communication (provide phone number): • _____ *For text communication to occur, accept the disclosure below	☐ Appointments/Reminders to Schedule
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	

Patient Rights:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- 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.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)