

# Confidential Communication Request (HIPAA Form)

From time to time in caring for our patients, it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed telephone messages when possible. In order to protect your privacy we need your written permission to leave detailed telephone messages on your answering machine or voice mail system. However, it should be noted that our current notice of privacy practices does allow us to call you with a courtesy reminder regarding any upcoming appointment(s).

**Please read the following choices and tell us whether or not we can leave voice mail regarding your medical information and with whom we may leave it with.**

**Choose one of the following:**

**I DO CONSENT to leave detailed messages as follows:**

I, \_\_\_\_\_, give **Caring Smile Dental** and their staff my permission to leave telephone messages regarding my medical care with the following options: (Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

- My home phone answering machine Initials \_\_\_\_\_
- My cell phone voicemail Initials \_\_\_\_\_
- My spouse (name) \_\_\_\_\_ Initials \_\_\_\_\_
- Other (name) \_\_\_\_\_ Phone number \_\_\_\_\_ Initials \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**I DO NOT CONSENT to leave detailed messages:**

I, \_\_\_\_\_, wish to be contacted personally and I DO NOT AUTHORIZE detailed messages regarding my medical care be left on an answering machine, voice mail, or with others.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Revocation of prior consent:**

I, \_\_\_\_\_, wish to rescind or stop the above authorizations.

Signature \_\_\_\_\_ Date \_\_\_\_\_

If not signed by patient, please indicate your relationship to the patient:

\_\_\_\_\_