Meadow Place Dental
200 North Main Street
East Longmeadow, MA 01028

HIPAA PATIENT COMMUNICATION FORM

It is the office policy of Meadow Place Dental not to release confidential medical information regarding your treatment to family members or friends, except for parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends or caretakers/babysitters, please indicate that below.

Home Phone_____
___DO NOT leave a message
___Leave a detailed message

Cell Phone _____
___ DO NOT leave a message
___ Leave a detailed message

Wk Phone_____
___DO NOT leave a message
___Leave a detailed message

May we **text** you? Yes No
May we **email** you? Yes No

Preferred email address:_____

By signing below, you authorize the following people to receive information regarding your treatment:
List names (please list relationship such as spouse, parent, boyfriend, girlfriend, sister, brother, etc

_____ _____

_____ _____

_____ _____

Who would you like us to contact ***in case of emergency:***

Name: _____ Relationship: _____

Phone Number: _____

If you wish to add names later on, please confirm in writing or call our staff directly.

Patient's Printed Name: _____ Patient's DOB: _____

Patient's Signature: _____

Today's Date: _____