Burns Family Dentistry

Elizabeth J. Burns, D.D.S.

2012 HIPAA DOCUMENTATION

Patient's name_____ DOB_____

Due to the federal privacy regulations, we cannot leave messages with protected health information on home answering machines or with family members without written permission from the patient/responsible party. Please complete the following information so we can keep in contact with you.

I give Burns Family Dentistry permission to leave detailed messages:

_____ on my HOME answering machine/voice mail

_____ on my WORK answering machine/voice

_____on my CELL phone#

_____with persons listed below (print name/relationship/phone number)

_____

_____

_____confirm appointments through e-mail

_____Okay to receive text messages

OR

____Please leave a call back number only. DO NOT leave a detailed message. (If checked we cannot speak to anyone listed about your health information.

Phone#_____I have received or I have been provided the opportunity to receive a copy of the "Notice of Privacy Practices" that explains when, where and why my confidential health information may be used or shared. I acknowledge that Elizabeth Burns D.D.S., the hygienist and other staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern Burns Family Dentistry operations and responsibilities.

SIGNATURE of patient/responsible party_____

Date_____

Please print name if signing for patient_____

Relationship_____

1455 Triad Center Drive
St. Peters, MO 63376

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