3631 Hoyt Ave, Everett WA 98201
P.425.259.5188 F.425.259.5189

CONSENT TO DISCUSS DENTAL CARE

Patient Name: _____
Please print

I authorize ***Westford Family Dental*** to discuss my dental information with the following individuals listed below:

Name: _____Relation: _____
Name: _____Relation: _____
Name: _____Relation: _____

☐ I AUTHORIZE ***WESTFORD FAMILY DENTAL*** TO LEAVE DETAILED MESSAGES ON THE PHONE NUMBERS LISTED:

_____ _____

☐ I DO NOT WISH TO HAVE DETAILED INFORMATION LEFT ON ANY OF MY PHONE NUMBERS LISTED.

_____
SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN DATE

_____
PRINTED NAME

CONSENT TO COMMUNICATE BY EMAIL

Our office is compliant with mandates from the government to make sure patients receive a summary copy of their visit if they did not receive it at the time of service. To accomplish this, we need your authorization to email.

EMAILS WILL NOT BE RELEASED TO ANY OUTSIDE ENTITY UNDER ANY CIRCUMSTANCE

I, _____give my authorization to ***Westford Family Dental*** to send any information about my personal chart to this email:

_____

_____
SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN DATE

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I understand ***Westford Family Dental*** will only disclose health information about me in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. I have the right to ask that some of my health information NOT be used or disclosed in the manner described in the Notices of Privacy Practices. I also understand Westford Family Dental is not required by law to agree to such requests. My signature below acknowledges I am aware of my rights in accordance to HIPAA.
By signing this form, I acknowledge that I understand the policies as outlined above. In addition, my signature permits Westford Family Dental to file claims to my insurance (if applicable). I also understand I accept financial responsibility for all services rendered regardless of insurance coverage.
Our patients and our relationships with our patients are very important to us. If you have any questions, concerns, or need assistance, please contact our office.

_____
PATIENT NAME DATE

_____
SIGNATURE OF PATIENT, PARENT OR LEGAL GUARDIAN DATE