HIPPA RELEASE FOR PROTECTED HEALTH INFORMATION

I,_____, date of birth_____, give David P. Robertson, DDS, PA, permission to speak to the following people regarding my health status, including diagnosis, treatment options and plans and payment for dental services I receive from David P. Robertson, DDS, PA

This consent is valid until such time as I provide David P. Robertson, DDS, PA written revocation of it.

David P. Robertson, DDS, PA may speak with:

Name: _____ Phone number: _____
Relationship: _____

Name: _____Phone number: _____
Relationship:_____

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of Dr. Robertson's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law, I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical/dental information:

RESTRICTIONS

May we call you at work?	Yes_____ No_____
Leave a message on your answering machine?	Yes_____ No_____
Call on a cell phone?	Yes_____ No_____
Text an appointment reminder?	Yes_____ No_____
Send an appointment reminder by e-mail?	Yes_____ No_____
Send an appointment reminder by mail?	Yes_____ No_____

Cell phone number _____

E-mail address _____

Patient's signature: _____ Date:_____

David P Robertson's Employee:_____ Date:_____

Restrictions accepted by Dr. Robertson's office Yes____ No ____