Patient Communication Consent Form

I agree to allow ***Beautiful Smiles*** to contact me in the following methods regarding my private health information, evaluation and treatment. I authorize ***Beautiful Smiles*** to leave messages for me when I am unavailable.

Method	Number/Address	Messages (Yes or No)
____ Home Phone	(____)_____	___Yes ___No
____ Cell Phone	(____)_____	___Yes ___No
____ Work Phone	(____)_____	___Yes ___No
____ Text Messages	(____)_____	___Yes ___No
____ Email	_____	___Yes ___No

____ Patient Portal

I authorize ***Beautiful Smiles*** to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with the contacts listed below. I understand that by leaving blank spaces I am indicating my choice to be a "No Information" and I do not want any information released to anyone else.

Name	Relationship to Patient	Contact Info

Emergency Contact Only

Name: _____ **Phone:** _____

By my signature below I acknowledge that I have read and understand the information provided on this consent form. I understand the risk associated with the different methods of communication, especially e-mail and texting, and consent to the conditions.

_____

Patient Name Printed **Date**

_____

Patient/Authorized signature **Relationship to patient**