



**CONSENT TO DISCUSS INFORMATION WITH OTHER INDIVIDUALS**

For Yourself - I, \_\_\_\_\_, hereby consent to allowing the office of **Mountain View Dental, pa** to discuss details of my dental status, billing information and care with the following individuals:

**OR**

For Your Child(ren) - I, \_\_\_\_\_, parent/legal guardian of  
(list all) \_\_\_\_\_

hereby consent to allowing the office of **Mountain View Dental, pa** to discuss details of their dental status, billing information and care with the following individuals:

<b>NAME (print):</b>	<b>RELATIONSHIP:</b>	<b>MAY DISCUSS ALL INFORMATION</b>
_____	_____	(Circle Y or N - if No, please note the info you do <b>not</b> want shared) Yes No _____
_____	_____	Yes No _____
_____	_____	Yes No _____
_____	_____	Yes No _____

Below are the patient’s rights with respect to this Authorization:

- You may revoke this authorization at any time by notifying Mountain View Dental, PA in writing at the address below. Revocation is only effective after it is received and logged by us, and any use or disclosure made prior to our receipt of the revocation will not be affected by the revocation nor will the revocation apply to disclosures made in reliance on this authorization. Unless this authorization is revoked sooner, as provided above, it will remain in effect until we replace it.
- You may refuse to sign this authorization and that any refusal to sign will not affect the patient’s ability to obtain treatment or payment.
- After this information is disclosed, federal and state law might not protect it and the recipient might disclose it.
- You may request and receive at no cost a paper copy of this authorization. A photocopy of this form shall have the same the legal weight as an original.



## CONSENT TO CONTACT BY PHONE OR OTHER MEANS

Unencrypted email and other forms of electronic correspondence, such as texting, are vulnerable to being intercepted, read, diverted or otherwise accessed by known or unknown parties. We cannot guarantee the security of such correspondence. If you would like us to proceed knowing these risks, please sign below and indicate your preferred modes of communication. Check and complete all that apply.

I hereby authorize the office of **Mountain View Dental, pa** to contact me by phone, e-mail and/or other means to leave message, verbal or written, for appointment reminders, callbacks, or other information.

- Check here if you would like us to communicate with you by email.  
Provide email address: \_\_\_\_\_
  
- Check here if you would like us to communicate with you by text. Provide  
SMS address/cell phone number: \_\_\_\_\_
  
- Check here if you would like us to communicate with you by phone.  
Provide phone number: \_\_\_\_\_
  
- Check here if you would like us to communicate with you by mail. Use  
mailing address on file.

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**Signature of Patient or Guardian**

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**Date**

GUARDIAN TO: \_\_\_\_\_