D E N T A L P A

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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 Children - 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:

NAME (print):	**RELATIONSHIP:**	**MAY DISCUSS ALL INFORMATION** (Circle Y or N - if No, please note what info you do **not** 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 if disclosed, federal and state law might not protect it and the recipient might redisclose 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, call backs 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: _____
- ☐ 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.

_____ _____

Signature of Patient or Guardian Date

GUARDIAN TO:_____

8 Clover Lane, Suite 2 P.O. Box 239 Whitefield, NH 03598-0239 **T:** 603 I 837 I 9342 **F:** 603 I 837 I 2890

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