



PALM HARBOR
FAMILY DENTISTRY

Emergency Contact / HIPAA Consent Form

Emergency Contact

In the event of an emergency, please list who you would like us to contact.

Emergency Contact Full Name: _____

Relation To The Patient: _____

Emergency Contact Phone Number: _____

HIPAA

Please read over our HIPAA policy before filling out this section. By signing this section, you are confirming that you have read or received a copy of our HIPAA PRIVACY POLICY.

Patient Signature: _____ Date: _____

If you DO NOT want us to disclose HIPAA information with anyone, do not fill out below.

I, _____ authorize and give my consent to Palm Harbor Family Dentistry and any of their staff members and personnel to disclose and discuss my entire dental records with no restrictions, including previous and future changes that may occur with my dental or health treatment with the person I have listed until I give a written notice to stop.

Please list the person you give office consent to disclose your HIPAA information with.

I authorize the office to speak with _____

who's relationship to me is _____

If there is HIPAA information you wish for us NOT to disclose with the name listed above, please list that here: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

This authorization will remain in effect until a written letter by the patient is received. This will also authorize Palm Harbor Family Dentistry to discuss all dates of treatment unless otherwise stated in writing by the patient.