Permission to communicate

Patient Name: _____

Date of Birth: _____

I authorize **Plainsboro Dental Care** to share my protected health information with family members or others as designated by me below. This permission is NOT an authorization to release medical records, or consent to treatment.

This permission also authorizes **Plainsboro Dental Care** to communicate with the authorized persons by phone (including voice messages), in person, or by other means acceptable to **Plainsboro Dental Care**.

Name:	
Phone Number:	Relationship to Patient:
Name:	
Phone Number:	Relationship to Patient:
Name:	
Phone Number:	Relationship to Patient:

I understand that I am under no obligation to provide **Plainsboro Dental Care** with this Permission to Communicate, and that **Plainsboro Dental Care** will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form. I understand that I may revoke this Permission if I so choose. I can revoke this Permission either by completing a new Permission to Communicate form and indicating my revocation on the form, or by notifying **Plainsboro Dental Care** in writing of my revocation. Communications should be sent to: 422 Plainsboro Road Plainsboro, NJ 08536. Attention: Privacy Officer.

NOT EFFECTIVE UNLESS SIGNED AND DATED

Signature of Patient: _____ Date: _____

Office Use Only: Administrative: HIPAA: Permission to Communicate
MRN_____