THIS IS A CONSENT FORM TO ALLOW US TO LEAVE A MESSAGE ON VOICE MAIL OR WITH INDIVIDUALS INVOLVED IN YOUR HEALTH CARE

Consent for disclosure of Protected Health Information ("PHI")

Name of Patient:	Phone Number: Other Number:
Date of Birth:	Social Security Number:

I (the undersigned) hereby consent to Eagle Creek Children's Dentistry leaving a voice mail message at the number(s) indicated above and/or discussing with the individual(s) listed below information related to my PHI. These communications may include, but are not limited to, appointment reminders, medications, pre-registration, insurance items, and any information pertaining to clinical health care services, such as laboratory and test results.

With my consent, Eagle creek Children's Dentistry may discuss my PHI with the following individuals

Name:	Date of Birth:
Relationship:	
Name:	Date of Birth:
Relationship:	
Name:	Date of Birth:
Relationship:	

I understand I have the right to revoke this consent at any time in writing, except to the extent Eagle Creek Children's Dentistry has already made a disclosure in reliance upon my prior consent. Unless revoked, this consent is valid for one year from the date of execution. A photocopy of a signed consent is acceptable, provided that it is apparent that the consent was signed and dated prior to photocopying.
I further understand that this consent does not permit the release of my actual medical records to the individual(s) listed above. Such release will only be made if I sign a separate valid authorization.

Signature of Patient, Guardian, or Health Care Representative:	Date: