Steven C. Wilburn D.M.D.
4755 Hoen Ave
Santa Rosa, CA 95405

Phone: (707) 542-2881
Email: staff@stevewilburndmd.com

AUTHORIZATION FORM

Today's Date : ____________________________

Patient Consent to Receive Mail and / or Telephone Messages

(Health Insurance Portability and Accountability Act **-HIPAA**)

____

Please Print (Last Name) *(First Name)* *(M.I.)*

____

Email Address

Do we have your permission to:

Send a recall appointment reminder to your home? Y ______ N______

Leave appointment, billing or dental information on your answering machine/voice mail? Y_______N_______

Send appointment information through your email? Y ______ N_______

I give permission to share appointment, billing or dental information with the person or people named below:

Name(s): ____

____

Signature of Patient / Parent of Legal Guardian *Date*

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices with an effective date of August 4, 2002.

____

Signature of Patient / Parent of Legal Guardian *Date*