TRAIL WEST
FAMILY DENTISTRY

COMMUNICATION CONSENT FORM

I consent to ***Trail West Family Dentistry*** contacting me electronically by the email address and/or cell phone below for the purpose of receiving appointment reminders, notification that I need to make an appointment, dental records, survey regarding dental visit, or reminders of uncompleted treatment.

I understand that during the transmission of these messages, the information contained at one point or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure. However, the practice will not transmit any personal or confidential information about your health, procedures or account status without your permission. (Please note that email messages from our office are encrypted if the message contains any personal health information).

I agree to inform the practice if my email address or cell phone number changes. I understand and acknowledge that I can cancel this consent at any time.

Email Address (please print clearly):_____

Cell Phone Number (for text messaging): _____

Do you give us permission to leave messages on these devices, such as appointment times, pre-treatment estimate amounts, pre-medication reminders (if applicable), ☐ **Yes** ☐ **No**

If you would **NOT** like to be contacted by email or text messages you may **Opt Out** of one or both by initialing below.* If you change your mind at any time, you may call us at (864) 246- 6471.

☐ I elect to **Opt Out** of email

☐ I elect to **Opt Out** of text messaging

PERMISSION TO RELEASE PRIVATE HEALTH INFORMATION

☐ PLEASE DON'T SHARE DENTAL INFORMATION

By checking box, you don't have to fill out any further information.

I hereby give permission to the following people to have access to my private health information:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I give permission to employees and staff of Trail West Family Dentistry to share my dental care and/or health history including records, diagnosis, recommended treatment, dates of any treatment recommended or rendered and costs of services and payment received associated with them. I acknowledge that this permission is optional and can be revoked by me in writing at any point in time. I also understand that this permission is in addition to permissions granted by signing Trail West Family Dentistry Practices and shall remain in effect until revoked.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____