Goolsby Family Dentistry

Notice of Privacy Consent

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions. However, if you do agree, then you are bound to abide by such restrictions. I further understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Do we have your permission to:

Leave a message on your voice mail at home or on your cell relating to an appointment? **( ) Yes ( ) No**

Mail a postcard to your home address reminding you of appointment made or needed? **( ) Yes ( ) No**

Call or leave a message at your place of employment? **( ) Yes ( ) No**

Discuss your medical/dental condition/treatment with any members of your household? **( ) Yes ( ) No**

***If yes, with whom:** _____ **Relationship** _____*

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