COMMUNICATION CONSENT

Rocky Point Family Dentistry
~~745 Route 25A~~ 809 RT 25A
Rocky Point, NY 11778

It is the policy of Rocky Point Family Dentistry in not to release confidential information other than face to facewithout **authorization** to do so by alternative methods (Voice Mail/Answering Machine/Telephone). Any information that will be provided will be released only to the authorized person (s) listed below.

I authorize Rocky Point Family Dentistry , and/ or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes (please fill out all contact information).

Home Telephone: _____-_____-_____ YES ____ NO____
Answering Machine: YES ____ NO ____
Work Telephone: _____-_____-_____ YES ____ NO ____

Cell/ Voice Mail: _____-_____-_____ YES ____ NO ____

E-mail: _____@_____.com YES ____ NO ____
Regular Mail: YES ____ NO ____

If you would like to have information released to someone other than yourself, please complete the following list of authorized people:

Spouse: _____ Tel: _____-_____-_____

Adult Child: _____ Tel: _____-_____-_____

Other (please indicate relation): _____ Tel: _____-_____-_____

Print Patient Name: _____ Preferred Tel: _____-_____-_____

Patient Signature: _____