RIVER TOWN DENTAL

PATIENT COMMUNICATION FORM

A. **FAMILY & FRIENDS:** It is the office policy of this Practice not to release confidential medical and health information regarding your treatment to family members or friends, except for 1) parent/legal guardian; 2) other persons authorized by the patient; 3) as we may reasonably infer from the circumstances (i.e., if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretaker/babysitters, please sign below so that we can release information to that person. If you do not want any of your medical or health information provided to a family member or friend, please check the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the practice in reliance on your original authorization. If you wish to cancel or change this agreement, please issue a letter in writing to Randall D. Moseng, DDS or Christopher J. Kerbaugh, DDS.

	Health Care Information	Financial Information
Spouse____________________	Yes____ No____	Yes____ No____
Parent____________________	Yes____ No____	Yes____ No____
Other____________________	Yes____ No____	Yes____ No____

2. **ALTERNATIVE COMMUNCATIONS:** You are also entitled to specialty alternative, reasonable means of communication, if you do not want to be contacted in a certain way.
I hereby request the following means of contact only______________________________

3. **TELEPHONE COMMUNICATIONS:** In order for River Town Dental to communicate with our patients regarding scheduling, appointments and billing by telephone; we must have authorization to convey designated information.

I authorize River Town Dental to leave any related information regarding my care at:
____ Home Telephone/Voicemail ____ Cell Telephone/Voicemail ____ Work Telephone/Voicemail

4. **ELECTRONIC ONLINE COMMUNICATION:** By signing below I agree that this practice may electronically communicate with me at the following e-mail address and text number regarding my family/patient account and/or information about any dental visit and/or treatment (upcoming or past).

E-Mail Address:______________________________ Text Message #:________________

By utilizing our practice's automated electronic communication services, you agree that River Town Dental may send to you any that you identify as communication that can be sent through the Internet or automated program(s) to an e-mail or text that you designate. Online communications that we are affiliated with do not sell, share or rent users' personally identifiable information unless required by law, do not send e-mail or other communications without user permission, and do not send spam. All electronic communications from our practice will be encrypted, I am responsible for providing this dental practice any updates to my e-mail address and text, I am able to receive information electronically and store it securely away from any public computer and I can withdraw my consent to electronic communications by calling the La Crosse office at 608-788-0030 or Holmen office at 608-526-9300.

Signature____ Date____________

____ Adult Patient ____ Parent ____ Guardian

***YOU MAY REQUEST A COPY OF THIS RELEASE