Patient Communication Form
Dr. Robert Metzger DDS

A. **Family and Friends.** It is the office policy of Robert Metzger DDS, not to release confidential medical information regarding your treatment to family members or friends, except for (i)parent/legal guardian, (ii)other persons authorized by the patient, (iii)as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment?, (iv)in emergency situations, or (v) as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please circle 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, or call our staff.)

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 canceling 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 call our office or issue a letter in writing.

	Health care information	**Financial information**
Spouse:_____	Yes No	Yes No
Parent:_____	Yes No	Yes No
Other:_____	Yes No	Yes No
_____	Yes No	Yes No

B. **Alternative Communications**. Please tell us if these ways to contact you are acceptable or not and if we can leave a message:

	OK to Contact	**OK to leave message**
Home phone:_____	Yes No	Yes No
Cell phone:_____	Yes No	Yes No
Work phone:_____	Yes No	Yes No
Text:_____	Yes No	Yes No
Email:_____	Yes No	Yes No
Traditional mail	Yes No	

Acknowledgment of Notice of Privacy Practices

I am a patient of Robert Metzger DDS. I hereby acknowledge receipt of Robert Metzger DDS's notice of privacy practices.

Name (please print):_____ Date:_____

Signature:_____

Or

I am a parent or legal guardian of (patient name)_____. I hereby Acknowledge receipt of Robert Metzger DDS's notice of privacy practices with respect to the patient.

Name (please print):_____Relationship to patient: Parent/Legal Guardian

Signature:_____ Date:_____