NEW RIVER VALLEY
DENTAL CARE

601 Roanoke Street, Christiansburg VA 24073
540-382-0201

HIPAA * Protected Health Information * Privacy Practices Notice

Name:_____Date of Birth:____/____/____

Release of Information

I authorize New River Valley Dental Care to disclose/discuss my Protected Health Information (PHI) with the following individuals:

_____Spouse:_____
_____Child/Children:_____
_____Other:_____
_____Information is not to be released to anyone

Messages

Please select and list the phone numbers that we can use to contact you:
_____Home #_____ _____Work #_____
_____Cell #_____ _____Other #_____

If we are unable to reach you, we have your permission to:
_____Leave a detailed message
_____Leave a message asking you to return our call (no details)
_____Other:_____

Notice of Privacy Practices

____I do ____I do not

Give consent for myself and/or my family to receive postcards, newsletters, appointment reminders, emails and/or phone calls about scheduled dental appointments or needed treatment. I also give permission to use my and my family's written, photographed or video testimonials for educational purposes.
____ (initial) I have received a full written description of the New River Valley Dental Care Privacy Policy to review and I have no questions regarding this policy (pages 2-3)

Signature:_____ Date ____/____/____
(Patient, Parent or Guardian)

Witness:_____ Date ____/____/____
(Staff Member)