Schneider Family Dentistry
Preferred Communication Methods and Contacts Form

Patient Name ______________________________ **Date of Birth** ______________

Preferred Communication:

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. Please tell us your preferred manner of communication. **You may update or change this information at any time; please do so in writing.**

I prefer to be contacted in the following manner (check all that apply):

- ☐ I approve email & text communications
- ☐ I approve email only
- ☐ I approve text only
- ☐ I prefer phone calls

Preferred Contacts:
We respect your right to tell us who you want involved in your treatment or to help with your payments. You may use this form to name specific individuals with whom you want us to share your information; this may include information about your general medical condition and diagnosis (such as treatment and payment options), access to medical records (PHI), prescription pick-up, and scheduling appointments. Please update this information in writing promptly if your preference changes.

Important Note: We may share your information as set forth in our Notice of Privacy Practices to other persons not named on this form as needed for your care of treatment or the payment of services we have provided.

Please indicate the person(s) you prefer we share your information with below:

Name	**Email**	**Phone**	**Relationship**

Patient Signature: ______________________________ **Date:** ______________
(To be signed by patient's parent or legal guardian if patient is a minor)