Drs. McClain and Schallhorn Periodontics & Dental Implants, P.C.

PATIENT AUTHORIZATION TO DISCUSS AND RELEASE PROTECTED HEALTH INFORMATION WITH OTHER INDIVIDUALS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits this office from discussing a patient's care and/or account information with other individuals. For this reason, your permission is needed if you want your medical and/or account information to be disclosed to another party. Once such permission is given, this permission will remain in effect until revoked in writing by the patient or guardian. , hereby authorize Drs. McClain & Schallhorn, P.C. and staff to contact and discuss my medical and/or financial information with the following person(s): Name: Relationship: Phone Number: Medical: Account: Y/NY/NY/NY/NY/NY/NY/NSigned by: Date of Birth Patient/Guardian Name Patient/Guardian Signature Date CONSENT FOR USE OF E-MAIL COMMUNICATION In an effort to communicate in a more timely and efficient manner, Drs. McClain & Schallhorn, P.C. may utilize encrypted e-mail for messages, including radiographs, to your referring and/or treating Dentists and Physicians. Drs. McClain & Schallhorn, P.C. and staff will use reasonable means to protect the security and confidentiality of E-Mail

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I acknowledge that I have read and fully understand the Consent for Use of E-Mail Communication form. I understand the risks associated with allowing the communication of e-mail amongst my Providers. I AGREE to allow Drs. McClain & Schallhorn, P.C. and/or staff to communicate via e-mail to my referring and/or treating Dentists and Physicians.

Patient/Guardian Name	Date	
Patient/Guardian Signature	_	

I do NOT wish for Drs. McClain & Schallhorn P.C. and/or staff to communicate via e-mail with my referring and/or treating Dentists and Physicians.