# BlueWave Dentistry

HIPAA CONSENT
CONSENT TO LEAVE MESSAGE

Patient Name:_____ Date:_____
(print)

I wish to be called at home ☐ ; other ☐ (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

_____home _____other

I do ☐, I do not ☐ give permission to leave relevant medical information on my answering machine or voice mail.

I do ☐, I do not ☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individuals(s) with whom you may leave pertinent information are:

_____

_____

_____ _____
Patient Signature Date