Stephanie A. Snelson, D.D.S.
1522 Edgemont Avenue
Bristol, TN 37620

In order to protect the privacy and confidentiality of your protected health information ___________________________________ and their staff members are requesting your permission to provide information to individuals other than yourself.

I agree/disagree that information directly related to my healthcare and billing can be released to family members, relatives, close personal friends or any other person(s) that are identified below.

I agree/disagree to be contacted by telephone for appointment confirmations, follow up regarding treatment or test results, in an emergency at work, and that you may leave messages on my answering machine.

Please identify individuals that you agree to allow _________________________________ and their staff members to communicate healthcare and billing information to;

Name:______________________________________DOB/Phone#:______________________

Name:______________________________________DOB/Phone#:______________________

Name:______________________________________DOB/Phone#:______________________

Name:______________________________________DOB/Phone#:______________________

Name:______________________________________DOB/Phone#:______________________

____
Signature of patient or legally authorized individual Date

____
Relationship to patient, if signed by anyone other than the patient
(Parent, legal guardian, personal representative, etc.)

The "Notice of Privacy Practices" for ____
has been made available for my review.

Patient initials_______________