Sedona Smiles

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Affordability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I have received or been offered the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information.

As indicated in the more detailed Notice of Privacy Practices, please inform us with whom you would like to have access, or discuss, your information by completing the following:

Name of Authorized Individual to discuss your care with Sedona Smiles Providers and team members	Relationship to patient

E-Mail and Text Messaging

Due to the changing world of healthcare and technology, we now have the ability to provide our patients with certain types of information via e-mail and/or text messaging.
We believe strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from us via e-mail or text messaging. We do not share names, e-mail addresses, and/or telephone numbers of patients with any other companies, or with any other patient.
By signing my name and date below, I acknowledge that I have read and understand the above statement on e-mails and text messages. I hereby give permission to send messages to me via e-mail and/or text messaging as a means of communication. Should I have any questions, I can contact the practice at any time.

Patient/Guardian Signature	Date
Printed Name	

Please indicate preferred method of communication with Sedona Smiles

- ☐ Email & Text
- ☐ Text Only
- ☐ Email Only
- ☐ None

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