PATIENT HIPPA ACKNOWLEDGEMENT AND CONSENT FORM

I, _____ have read / received a copy of Gloria E Ward, D.D.S.,M.S., M.I.S., P.C. 's Notice of Privacy Practices with an effective date of March 11, 2017.

I authorize you to release my personal health information to the following individual(s): (I understand I may change this list at any time).
Please print:

Name	Relationship	Contact number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I consent to receiving emails or texts/messages from the practice at my cell phone and any number forwarded or transferred to that number provided, or emails to receive communications. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

The cell phone number that I authorize to receive detailed texts/messages for appointment reminders, feedback and general health reminders/information is: _____

The email that I authorize to receive detailed texts/messages for appointment reminders, feedback and general health reminders/information is: _____

_____ _____
Signature of patient Date

_____ _____
Signature of Witness Date