# Consents

**A) Communication Consent**

Purpose: This consent is used to obtain authorization to release information regarding yourself, covered under the Privacy Act, to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

1) _____ 2) _____

(Please Print Name/s & Relationship)

***Signature***: _____ Date: _____

**B) Electronic Communications**

By submitting your email address to our practice you have granted us permission to communicate with you electronically. By utilizing our practice's electronic services, you agree that WALTON DENTAL CARE may send to you any of the following that can be sent through the internet to an email address you designate.

I, _____, agree that Walton Dental Care may electronically communicate with me at the following email address.

Email Address: _____

Patient's Name & Date of Birth: _____

_____

Acknowledgement and Consent that Walton Dental Care may send the following by email:

Information about my invoice or accounts payable, any dental visits (including appointment reminders), photos and x-rays, or any information that I request be sent by email.

Communications from our practice will be encrypted, the patient is responsible for providing the dental practice with an updated email address, the patient is able to receive information electronically and store it securely away from any public computer and I can withdraw my consent to electronic communications by calling the office at 770-267-2301.

***Signature***: _____ Date: _____

**C) Photography**

Patient/s Name/s: _____ DOB/s: _____

I consent to have my child's (or the individual to whom I provide guardianship) photograph taken by the staff for the "No Cavity Club" boards that are on display in the hygiene operatories.

Walton Dental Care understands that your privacy is very important. If the images are to be taken for any purpose other than for what is mentioned, it must be stated and your permission must be obtained.

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

By signing below, I am indicating that I have read and understand this consent. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

***Parent or Legal Guardian Signature***: _____ Date: _____