



2505 A Evelyn Byrd Ave.
 Harrisonburg, VA 22801
 P: 540.433.8814 | F: 540.433.7110
A healthy smile is a life-long smile.

Name of Patient _____ **Date of Birth** _____

Authorization for Patient Communication

Kray Orthodontics would like to offer you the ability to receive text message or email reminders for your appointments. We are also able to email financial and medical information. I agree to allow Kray Orthodontics to contact me in the following manner:

<input type="checkbox"/> Email communication – Provide email address _____	<ul style="list-style-type: none"> ● Appointment reminders ● Financial or Medical information
<input type="checkbox"/> Text communication – Provide number _____	<ul style="list-style-type: none"> ● Appointment reminders

Authorization for Patient Photos

Kray Orthodontics likes to share our fun with others through photos posted on social media as well as around the office. I agree to allow Kray Orthodontics to post photos of me in the following manner:

<p>Please check the box that applies</p>	
<input type="checkbox"/> May be posted in office	
<input type="checkbox"/> May be posted on website/social media	
<input type="checkbox"/> May NOT be used for anything other than medical purposes	

Patient Rights

- I have the right to revoke this authorization at any time
- I may inspect or copy the protected health information to be disclosed as described in this document
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing
- This authorization will remain in effect until revoked by the patient

 Signature of Patient (Parent or Guardian if Child) Date _____