# CLARK J. WRIGHT, D.M.D., P.A.

## Patient Consent to receive Mail and/or Telephone Messages

Please Print (LAST NAME) ________ (FIRST NAME) ________ (M.I.) ________

**Do we have your permission to:**

Send a recall appointment reminder to your home? Y______ N______

Leave appointment, billing or dental information on Your answering machine/voice mail/ e-mail: Y______ N______

I give permission to share appointment, billing or dental information with the person named below:

Name: ______________________________

______________________________ ____________
Signature of Patient/Parent or Legal Guardian Date

## Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy or have been made aware of the Notice of Privacy Practices with an effective date of April 14, 2003.

______________________________ ____________
Signature of Patient/Parent or Legal Guardian Date

4140 WOODMERE PARK BLVD., SUITE 1 • VENICE, FLORIDA 34293 • TELEPHONE (941) 493-5923