NAME OF OFFICE: Family Dental Centre

ADDRESS OF OFFICE: 924 Williams Park Dr.
Bedford, IN 47421

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,_____, Date of Birth_____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- Sensitive Protected Health Information (HIV- related information)
- You may disclose information to my family members and/or non-family members
  Please list the name, phone number and relationship

NAME PHONE NUMBER RELATIONSHIP

_____

_____

_____

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_____

- You may leave Protected Health Information on my answering machine/voicemail: Phone Number_____
- You may leave me a text message: Text Phone Number_____
- You may email me (unencrypted) for dental appointments:
  Email Address:_____
- You may fax me for dental information: Fax Number_____
- Other_____

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

Signature:_____

(Patient's Signature (or Guardian, if minor)

Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)