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, and 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**

_____

_____

_____

_____

_____

- You may leave Protected Health Information on my answering machine/voicemail:
  Phone: _____
- You may leave me a text message:
  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: _____ Date: _____

Signature: _____

Patient Signature (or Guardian, if the patient is a minor)

FOR OFFICE USE ONLY

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

- ☐ The individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment