Center Grove Family Dentistry

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,___________________________________, 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

- You may leave Protected Health Information on my answering machine/voicemail: Phone Number______________________
- You may email me (unencrypted) for dental appointments:
  Email Address:___________________________________

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

Print Name:____

Signature:____

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

Date:____