

NAME OF OFFICE: Pediatric Dental Specialists of Indiana, P.C.
2705 S. Berkley #2B, Kokomo, IN 46902

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

Patient Name

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

Parents,
Guardian
Anyone
who can
have
access
to
patient
info

NAME

PHONE NUMBER

RELATIONSHIP

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- You may leave Protected Health Information on my answering machine/voicemail:
Phone Number _____

Address Update: _____

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) _____

Medical History Update: _____
