Columbia City Dentists

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

Patient name: _____ Date of birth: _____ / _____ / _____

I request that the following be followed for the disclosure of my Protected Health Information. 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

I authorize messages containing Protected Health Information on my answering machine/voicemail:

Patient (or guardian) Signature: _____ Date: _____ / _____ / _____

I authorize my x-rays to be sent via e-mail for referral purposes:

Patient (or guardian) Signature: _____ Date: _____ / _____ / _____

I have been offered a copy of this office's Notice of Privacy Practices:

Patient (or guardian) Signature: _____ 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) _____

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