

Premier Dental Care
6920 S. East Street, Suite A
Indianapolis, In. 46227
(317) 787-6625

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth: _____,

Request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include, but not limited to, your name, diagnosis(es), test results, and dates of service.

PLEASE CHECK ALL THAT APPLY

___ You may disclose information to my family members and or non-family members. Please list name, phone number and relationship.

NAME	PHONE NUMBER	RELATIONSHIP

___ You may leave Protected Health Information on my answering machine/voicemail.

Telephone Number: _____

___ Other: _____

Patients Printed Name: _____ Social Security Number: _____

Patients Signature: _____ Date: _____
(Or Guardian, if minor)

Witness (optional): _____ Date: _____