THE EXTRA SMILE

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 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 information on my answering machine/voicemail.
Phone Number: _____
You may leave information as an E-mail message.
E-mail address: _____
You may disclose information to a referring dental office.

Acknowledgement of Receipt of Privacy Practices Notice
I,_____,acknowledge that I have received a Notice of Privacy Practice form above- name Practice

Signature:_____ Date:_____
*If a personal representative signs this authorization on behalf of the individual, complete the following :

Personal Representative's name _____
Relationship to individual _____

Patient Signature: _____ Date: _____