BLOOM DENTAL

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

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

NAME PHONE NUMBER RELATIONSHIP

_____

_____

_____

*You may leave Protected Health Information on my answering

machine/voicemail: Phone Number _____

*You may leave me a text message: Text Phone Number _____

*You may email me (unencrypted) for dental appointments:

Email Address: _____

*You may fax me for dental information: Fax Number _____

*Other _____

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

Print Name: _____

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 (Specify) _____

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