NAME OF OFFICE: SCHROEDER COSMETIC DENTISTRY
ADDRESS OF OFFICE: 8028 E. TENTH ST. INDIANAPOLIS, IN 46219
317-897-8028

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 dental information: Fax Number _____
- Other _____

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) _____