Prosthodontics of Central Indiana
11405 Pennsylvania Street, Suite #110, Carmel, IN 46032

## *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 |
|---|---|---|
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- 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 appointments:
  Email Address: _____
- 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): _____