CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,____,Date of Birth:___________,

request that the following guidelines be used for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es), test results, dates of treatment and related issues.

PLEASE CHECK ALL THAT APPLY

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

NAME	PHONE #	RELATIONSHIP

☐ You may leave Protected Health Information on my answering machine or voice mail at the following phone number(s).____________________________

☐ Other ____

____
Patient's Printed Name

____
Social Security Number

____
Patient's Signature(or Guardian, if minor)

____
Date

Office of Dr. Jon M.Roberts, D.D.S.