HAMILTON CO. PEDIATRIC DENTISTRY

Contact Information for Protected Health Information

I, _____, for _____ (DOB) _____, request that the following be followed for the disclosure of
(Guardian) (Patient)
Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results and date of services.

You may disclose information to the family members and/or non-family members listed below:

Name	Relationship	Phone Number

Please check all that apply:

- ☐ You may leave Protected Health Information on my answering machine/voicemail: Phone Number _____
- ☐ You may send me a text message: Phone Number _____
- ☐ You may email me (unencrypted) for dental appointments: Email address _____
- ☐ You may email x-rays (unencrypted) to dental specialists for consultation and/or treatment purposes

  OR

- ☐ I request for all x-rays to be securely mailed to dental specialists for consultation and/or treatment purposes.

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

Print Name: _____

Signature: _____ 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)

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