South Indy Family Dentistry
5150 E Stop 11, Suite 11
Indianapolis, IN 46237

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, ____, Date of Birth_____________, request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis (es), tests results, and dates of service.

PLEASE CHECK ALL THAT APPLY

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

Name	Phone Number	Relationship

- ○ You may leave Protected Health Information on my answering machine/voicemail. If yes what telephone number may we contact you? _______________________________
- ○ You may call me at work. Phone number _______________________________
- ○ You may mail me reminders of my appointments.
- ○ You may contact my employer concerning insurance denials and additional information for filing a claim.
- ○ You may disclose insurance information to a referring dental office.
- ○ Other ____

_________________________ _________________________
Patient's Printed Name Social Security Number

_________________________ _________________________
Patient's Signature (or Guardian, if minor) Date

____
Address City State Zip code