NAME OF OFFICE: Kessler Family Dentistry

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.**
- **Phone Number: _____**
- **Other: _____**

You may disclose insurance information to a referring dental office.

_____ _____

Patient's Signature Date

_____ _____

Patient's Printed Name Social Security Number

_____ _____

Witness (Optional) Date