

# Hamilton County Endodontics

14757 Oak Road, Suite 400  
Carmel, IN 46033

## Contact Information For Protected Health Information

I, \_\_\_\_\_, Date of Birth \_\_\_\_\_, request that the following be used for disclosure of my Protected Health Information (PHI). Protected Health Information includes your name, diagnosis, test results, insurance, and date of services.

You may disclose information to my family members and/or non-family members, listed below.

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- You may leave Protected Health Information on my answering machine/voicemail: Phone Number \_\_\_\_\_
- Other \_\_\_\_\_
- You may disclose insurance information and Protected Health Information to my dentist.

### I have received a copy of the HIPAA Notice of Privacy Practices

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

(Patient's Signature or Guardian's Signature & relationship if minor)

Date: \_\_\_\_\_

**Emergency Contact:** (if different than the person/persons above):

\_\_\_\_\_