NAME OF OFFICE: CORNERSTONE DENTAL ARTS
ADDRESS OF OFFICE: 920 NORTH STATE STREET GREENFIELD, IN 46140

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I _____, Date of Birth_____, request that the following be followed for the disclosure of my Protected Health information (PHI). Protected Health Information would include your name, diagnosis and estimate of treatment that needs to be done, test results, dates of service, scheduled appointments, and your insurance information.
You may disclose information to my family members and or non-family members. Please list the name, phone number and relationship

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail. Phone Number: _____
- Other: _____

_____
Patient's Printed Name

Social Security Number

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

Date

_____ _____
Witness (optional)

Date