Dental Care Today, PC
9744 Lantern Road
Fishers, IN 46037-9612

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), test results, 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:____

____________________________ ____________________________
Patient's Printed Name Social Security Number

____________________________ ____________________________
Patient's Signature (Guardian, if minor) Date

____________________________ ____________________________
Witness (optional) Date