CONSENT FORM FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION II

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PROTECTED HEALTH INFORMATION (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I authorize Dr. Derek B. Hauser, DDS and staff to contact me in the following manner:

(mark all that apply)

__ Home Telephone: ____________________
   __ please leave a message with detailed information.
   __ do not leave information

__ Mobile Telephone: ____________________
   __ please leave message with detailed information.
   __ do not leave information

You have my authorization to release detailed information including results to:

__ My Spouse: ____________________
   Spouse’s name

__ Family Member: ____________________
   Name of person

__ Other ____________________
   Name and relation to patient

__________________________________________________________________________________________________________

Print Patient/Guardian Name   Signature of Patient/Guardian   Date