Lakefront Family Dentistry and or Derek B. Hauser, DDS

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 INFOMATIONS (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