

---

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 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