BATESVILLE DENTAL 391 NORTHSIDE DR BATESVILLE, IN 47006 812-934-3651

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION The following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es), tests 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. Relationship Phone Number Name You may leave Protected Health Information on my answering machine/voicemail. Yes or No- Text Can we send text messages or email reminders of your appointments? Yes or No- Email Email Address Social Security Number Patient's Printed Name Date Patient's Signature (or Guardian, if minor) Date Witness (optional) You May Refuse to Sign This Acknowledgment E have received a copy of this office's Notice of Privacy Practices. Print Name:_____ Signature:_____ Date:

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