

Ellettsville Dental Center

5915 West Highway 46 · P.O. Box 518 · Ellettsville, Indiana 47429

Telephone: (812) 876-7330

HIPAA INFORMATION: I acknowledge that I have received and read a copy of the HIPAA Notice of Privacy Practices. This notice describes how my Protected Health Information about me may be used and disclosed and how I can access this information. The Notice of Privacy Practices is based on current federal law and subject to change based on changes in federal law or subsequent interpretative guidance.

Initial _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION: I authorize my provider to release information from my health information to my insurance carrier(s) for processing of claims for my benefit. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my provider, on my behalf.

Initial _____

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION: I request that the following be followed for the disclosure of my Protected Health Information (which include your name, diagnosis(es), test results, dates of service).

Please check all that apply

- You may disclose information to my family members 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 Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Address: _____ Birthdate: _____