HIPPA INFORMATION

PATIENT NAME_______________________________________PHONE #__________________

_______ I give permission to discuss my Protected Health Information (PHI) with the Following person(s), this includes discussions about my bill.

Name	Relationship	Phone #
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

_________ Do not discuss my Protected Health Information (PHI) with anyone other than myself, this includes discussions about my bill.

_________ I give permission to leave a message:

- ______ With person(s) listed above.
- ______ On voicemail at home.
- ______ On my cell phone.
- ______ On my work voicemail.
- ______ Other Please list: ______________________

______ Do not leave message.

Patient Signature:____Date:__________________

*The above information will be in effect until the patient has informed Monument Family Dentistry of any changes.