CAPITOL DENTAL CENTER - PATIENT DISCLOSURE INSTRUCTIONS

In general, 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 be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

HOME TELEPHONE_____
_____ It is okay to leave a message with detailed information
_____ Leave me a message with the call-back number only

CELL PHONE_____
_____ It is okay to leave a message with detailed information
_____ Leave me a message with the call-back number only

WRITTEN COMMUNICATION
_____ It is okay to send mail to my home address
_____ It is okay to send mail to my work/ office address
_____ It is okay to send a FAX to the number indicated: _____
_____ **I agree that Capitol Dental Center may communicate with me electronically at the Email address below**. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by calling: 651-222-1201

My Email Address: _____

WORK TELEPHONE_____
_____ It is okay to leave a message with detailed information
_____ Leave me a message with call-back number only

I ALLOW YOU TO GIVE MY CLINICAL INFORMATION TO, OR TO ANSWER QUESTIONS FROM THE FOLLOWING PEOPLE (CHECK ALL THAT APPLY):
_____ My spouse_____
_____ My parent _____
_____ My child _____
_____ Other (specify); _____
_____ Nobody

_____   _____
Patient Signature   Date

_____   _____
Print Name   Birth Date