Health Information Privacy
(HIPAA)

Name: ______________________________ Date: _______________________

May we leave a message at home? Yes/No home number: __________________

May we leave a message on your mobile? Yes/No mobile number: _____________

May we leave a message at work? Yes/No work number: ____________________

Please list all persons to whom we may talk concerning your dental care:

1. ____

2. ____

3. ____

4. ____

Signature: ______________________________________