

Donald S. Bland, DDS

HIPAA Patient Disclosure Instructions

Name: _____ Date of Birth: _____

Parent/Guardian: _____ Relationship: _____

I wish to be contacted by phone in the following manner:

Ok to leave message with detailed information (circle all that apply): Home Cell Work

Leave message with CALL BACK NUMBER ONLY: Home Cell Work

Who may we leave detailed message with:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

If sedated who will be your escort?

Name _____ Relationship _____ Phone _____

I allow you to give my clinical or personal information to or answer questions from the following:

The dental or health insurance carrier that I have provided.

___ My Physician Dr. _____

___ Other _____

My preferred pharmacy is: _____ Location: _____

I understand that Dr. Bland or his staff can provide me a copy of the Notice of Privacy Practices if I request one. I understand the HIPAA disclosure information above.

Signature: _____ Date: _____

HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided with the right to request confidential communications or that a communication of PHI may be made by alternative means, such as sending correspondence to the individual's office instead of their home.