**INDIANA FAMILY DENTISTRY, L.L.C.**
**505 N. Green Street**
**Brownsburg, IN 46112**
**317-852-5999**

**HIPAA CONTACT CONSENT FOR PROTECTED HEALTH INFORMATION**

I, _____, Date of Birth: ___/___/_____, consent to the disclosure of my Protected Health Information under HIPAA, which may include my name, diagnoses, prognoses, test results, and the dates and descriptions of all treatment needed as well as received, including all fees related to these services, to the person or persons listed below:

| NAME | RELATIONSHIP | PHONE NUMBER |
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Please indicate with a check if we may leave messages pertaining to your Protected Health Information on the following automated systems:

Answering Machine: Home Yes_ _No_ _
Answering Machine Work Yes_ _No_ _
Voicemail Home/Cell Yes_ _No_ _
Voicemail Work Yes_ _No_ _
E-mail. Yes_ _No_ _
Other_____Yes_ _No_ _

_____ _____
***Printed Name of Patient*** ***Date***

_____ _____
***Patients Signature (Guardian, if Minor)*** ***Date***

_____ _____
***Witness (optional)*** ***Date***