JOHN R. KASHMANIAN, D.M.D.

15A Searles Road
Pomfret Center, CT 06259
860-928-7487

55 Everett Street
Southbridge, MA 01550
508-765-0099

PATIENT RECORD OF DISCLOSURE

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses of disclosures of protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is 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):

_____ OK to leave message with detailed message on Home Telephone # _____

_____OK to leave message with detailed message on Work /CellTelephone # _____

_____Written Communication to home address

VERBAL RELEASE OF INFORMATION

John R. Kashmanian, D.M.D. is allowed to give verbal medical information or updates about your condition to your Power of Attorney or Healthcare/Legal Representative as listed in your medical record.

If you wish others, such as doctors, relatives or friends, **who ask** about your condition, the right to be verbally informed about your condition when they ask, please list the names of those people on the lines below.

I am authorizing the release of verbal medical information regarding treatment, care and updates on my medical condition to the following individuals:

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

- I understand that **John R. Kashmanian, D.M.D.** will continue to rely on the information on this form when communicating with family members or others involved in my care, unless I request changes.
- I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I **must do so in writing** and the revocation will not apply to the information that has already been disclosed prior to the receipt of written revocation.

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PRINTED NAME DATE OF BIRTH