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):

_____Home Telephone # ____________________________
_____OK to leave message with detail information
_____Leave message with call-back number only

_____Work Telephone # ____________________________
_____Leave message with call-back number only

_____Written Communication
_____OK to mail to my home address
_____OK to fax to this # ___________________

_____OTHER:
____

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