1 Kathleen Drive Jackson, NJ 08527
(732)363-6633 nufamilydental@gmail.com

DISCLOSURE DESIGNATION OF RELATIVES AND/OR OTHER CAREGIVERS

I agree that NU Family Dental may disclose certain of my health information to a family member and/or caregiver, since such person is involved with my health care or payment relating to my health care. In that case, NU Family Dental will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I wish to be contracted in the following manner (please check all that apply):

You can disclose my health information as described below:

1.___ OK to leave message(s) with detailed information at my home number (___)____-_____ and/or mobile number(___)____-_____

___ On my answering machine

___ With my spouse

___ With anyone answering the phone

___ Leave message with call back numbers only

2.___ OK to leave message(s) with detailed information at work number(s) (___)____-_____

___ Leave message with call back numbers only

3.___ OK to fax information to this number (___)____-_____

4.___ OK to email. Email Address ____

5.___ OK to text to my mobile number (___)____-_____

The following persons are authorized to receive my Patient Health Information:

Name:____ Relationship:______________________

Name:____ Relationship:______________________

Signature:______________________________Printed Name:_____________________ Date______

Patient or Authorized Representative