DR. RYAN J. GREENE
3811 Fairview Drive, Anderson IN 46013

GREENE ENDODONTICS

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth _____, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, and/or dates of service.

- Sensitive Protective Health Information (HIV—related information)
- You may disclose information to my family members and/or non-family members. *Please list the name, phone number, and relationship.*

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- YOU MAY LEAVE Protected Health Information on my answering machine/voicemail. That phone number is: _____
- Other: _____

_____ _____

Patient's Printed Name | Social Security Number

_____ _____

Patient's Signature | Date

_____ _____

Witness (Optional) | Date

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