Franklin Dentistry Associates, P.A.

HIPPA Access Form for Protected Health Information
Effective date is three days from date of signature

I understand that it is the policy of Franklin Dentistry Associates, P.A. to restrict access to my Protected Health Information. In addition to the caregiver(s) providing health services, and my insurance company(ies) for payment of my claim, I would like the following person/people to have access to my Private Health Information:

	Name(s) Please Print	DOB	Access Preferences
1.	Myself (patient or legal guardian	N/A	_all _____
2.	_____	_____	_all _____
3.	_____	_____	_all _____
4.	_____	_____	_all _____
5.	_____	_____	_all _____

Communication:

You may leave confidential information on my
___answering machine
___cell phone voice mail
___voice mail @ work

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date