Dr. William J. Holevas

1209 Dundee Avenue

Elgin, Illinois 60124

**COMMUNICATION POLICY**

In general, the HIPPA privacy rule gives you the right to request a restriction on uses and disclosures of your protected health information (PHI). You are also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

**I MAY BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):**

Home Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_OK to leave message with details \_\_\_ OK to leave message with details

\_\_\_Leave call back number \_\_\_Leave call back number

 \_\_\_OK to leave a text

Work Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Written Communication

\_\_\_OK to leave message with details \_\_\_OK to mail to my home address

\_\_\_Leave call back number \_\_\_OK to e-mail

Certain conditions in the mouth can adversely affect medications and other related health issues in the body. If we feel it is important for your physician to be aware of such conditions, please indicate who you would like us to share our findings with:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ I DO NOT want my protected health care information to be released to the following:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dependents under the Age of 18 Covered by this release:**

Name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name and DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY RULES**

I have received a copy of the Notice of the Privacy Practices for the office of Dr. William Holevas

Sign and Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_