ADDITIONAL INFORMATION DISCLOSURE FORM

1. I authorize that my name will be signed on a “community” sign in sheet where others may see my name.
2. I authorize that my name will be put in a schedule book upon making appointments, this book is open faced.
3. I authorize that my information may be used to send me mail or email for such items like: birthday cards, Holiday cards, reminder cards, or special events.
4. I authorize that my information may be used for the office “Thank You” board, which may consist of my name.
5. I authorize any employee of the practice to call me at my residence or at work and speak with me or leave me a message regarding my treatment on any recording device, including leaving messages with family members.
6. I authorize that if I give the practice a testimonial of the care rendered to me, it may be placed in a book that other patients may read.
7. I authorize my photograph to be taken and used within the office.

PROTOCOL FOR PRESERVATION OF PATIENT RECORDS

Pursuant to ARS 32-3210 and the requirements of the State of Arizona for the preservation of patient records, this document is intended to inform all patients of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. We agree to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

We will maintain your records for a period of seven (7) years following your last date of service. After 7 years from the last date of service, we reserve the right to destroy your records. Should we exercise that right, we will first attempt to contact you and inform you of your right to obtain a copy of these records. We will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should we or any health care professional directly associated with us, retire, cease to practice, or sell his/her practice to another health care professional, we will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient’s last known address.