Patient ID: (Internal Use) _____ Date: _____

Patient Information

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number	Driver's License Number/ID Number		Date of Birth
Height Weight	Home Phone	Cell Phone	Email Address
Occupation	Employer Name		Employer Phone
Employer Address	City	State	Zip
Emergency Contact Name	Relationship	Home Phone	Cell Phone

If you are completing this form for another person, what is your relationship to that person?
Your Name Relationship

How did you first hear about our office?
☐ Patient (Name) _____ ☐ Employee (Name) _____ ☐ Dental or Medical Office: (Please Specify): _____
☐ Drive By Office ☐ Google ☐ Insurance Company ☐ Other (Please Specify): _____

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	YES	NO	DK
Active Tuberculosis	☐	☐	☐
Persistent Cough Greater than a 3-week duration .	☐	☐	☐
Cough that produces Blood	☐	☐	☐
Been Exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Person Responsible for Account ☐ Check Here if Same As Above

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number	Driver's License Number/ID Number		Date of Birth
Home Phone	Cell Phone	Email Address	
Occupation	Employer Name	Employer Phone	
Employer Address	City	State	Zip

Dental Insurance Information ☐ I Do NOT have Dental Insurance

Subscriber's (Insured) First and Last Name	Subscriber's (Insured) Date of Birth		Subscriber's (Insured) Social Security Number
Name of Subscriber's (Insured) Employer	Patient Relationship to the Subscriber		
Insurance Company Name	Phone Number	Subscriber ID #/ Policy ID #	Group ID/Name/#
Insurance Company Address	City	State	Zip

Secondary Dental Insurance Information ☐ I Do NOT have Secondary Dental Insurance

Subscriber's (Insured) First and Last Name	Subscriber's (Insured) Date of Birth		Subscriber's (Insured) Social Security Number
Name of Subscriber's (Insured) Employer	Patient Relationship to the Subscriber		
Insurance Company Name	Phone Number	Subscriber ID #/ Policy ID #	Group ID/Name/#
Insurance Company Address	City	State	Zip

Dental Information

	YES	NO	DK
Does your gums bleed you brush or floss?.....	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?.....	☐	☐	☐
Is your mouth dry?.....	☐	☐	☐
Have you had any periodontal (gum) treatments?.....	☐	☐	☐
Have you ever had orthodontic (braces) treatment?.....	☐	☐	☐
Have you had any problems associated with previous dental treatment?.....	☐	☐	☐
Is your home water supply fluoridated?.....	☐	☐	☐
Do you drink bottled or filtered water?.....	☐	☐	☐
If yes, how often? (*Check one:)* DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you cur rently experiencing dental pain or discomfort?.....	☐	☐	☐
Do you have earaches or neck pains?.....	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?....	☐	☐	☐
Do you brux or grind your teeth?.....	☐	☐	☐
Do you have sores or ulcers in your mouth?.....	☐	☐	☐

	YES	NO	DK
Do you wear dentures or partials?.....	☐	☐	☐
Do you participate in active recreational activities?.....	☐	☐	☐
Have you ever had a serious injury to your head or mouth?.....	☐	☐	☐

Date of your last dental exam: _____

What was done at that time? _____

Date of last dental x-rays: _____

What is the reason for your dental visit today? _____

_____

How do you feel about your smile? _____

_____

Medical Information

	YES	NO	DK
Are you now under the care of a physician?.....	☐	☐	☐

Physician Name: _____

Phone #: _____

Are you in good health?.....	☐	☐	☐
Has there been any change in your general health within the past year?.....	☐	☐	☐

	YES	NO	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	☐	☐	☐
Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....	☐	☐	☐

Date of last physical exam:_____

If yes, what was the illness or problem?_____

_____

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements: _____

If yes, what condition is being treated?_____ _____	_____ _____

Medical Information (continued)

Do you wear contact lenses?..... YES ☐ NO ☐ DK ☐	Do you use controlled substances (drugs)?..... YES ☐ NO ☐ DK ☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?..... ☐ ☐ ☐ Date: _____ If yes, have you had any complications? _____	Do you use tobacco (smoking, snuff, chew, bidis)?..... ☐ ☐ ☐ If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED
Are you taking or scheduled to begin taking an antiresorptive Agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) forosteoporosis or Paget's disease?..... ☐ ☐ ☐	Do you drink alcoholic beverages?..... ☐ ☐ ☐ If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____
Since 2001, were you treated or are you presently scheduled to Begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA)for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?..... ☐ ☐ ☐ Date Treatment began: _____	WOMEN ONLY Are you: Pregnant?..... ☐ ☐ ☐ Number of weeks: _____ Taking birth control pills or hormonal replacement?..... ☐ ☐ ☐ Nursing?..... ☐ ☐ ☐

Allergies. Are you allergic to or have you had a reaction to:	YES	NO	DK
To all yes responses, specify type of reaction.			
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐

Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	YES	NO	DK
Artificial (prosthetic) heart valve.....	☐	☐	☐
Previous infective endocarditis.....	☐	☐	☐
Damaged valves in transplanted heart.....	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD.....	☐	☐	☐
Repaired (completely) in last 6 months.....	☐	☐	☐
Repaired CHD with residual defects.....	☐	☐	☐

**** Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.***

	YES	NO	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....	☐	☐	☐

Name of physician or dentist making recommendation: _____
_____ Phone # _____

Do you have any disease, condition, or problem not listed that you think I should know about?.....	☐	☐	☐

Please explain: _____

	YES	NO	DK
Cardiovascular disease..	☐	☐	☐
Angina.....	☐	☐	☐
Arteriosclerosis.....	☐	☐	☐

Congestive heart failure	☐	☐	☐
Damaged heart valves...	☐	☐	☐
Heart attack.....	☐	☐	☐
Heart murmur.....	☐	☐	☐

Low blood pressure.....	☐	☐	☐
High blood pressure.....	☐	☐	☐

	YES	NO	DK
Other congenital heart defects.....	☐	☐	☐
Mitral valve prolapse...	☐	☐	☐

Pacemaker.....	☐	☐	☐
Rheumatic fever.....	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding.....	☐	☐	☐
Anemia.....	☐	☐	☐

	YES	NO	DK
Blood transfusion.....	☐	☐	☐
If yes, date:_____			
Hemophilia.....	☐	☐	☐
AIDS or HIV infection...	☐	☐	☐
Arthritis.....	☐	☐	☐
Autoimmune disease...	☐	☐	☐
Rheumatoid arthritis....	☐	☐	☐
Systemic lupus erythematosus.....	☐	☐	☐
Asthma.....	☐	☐	☐
Bronchitis.....	☐	☐	☐
Emphysema.....	☐	☐	☐
Sinus trouble.....	☐	☐	☐
Tuberculosis.....	☐	☐	☐

	YES	NO	DK
Cancer/Chemotherapy/ Radiation Treatment....	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain.....	☐	☐	☐
Diabetes Type I or II.....	☐	☐	☐
Eating disorder.....	☐	☐	☐
Malnutrition.....	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn.....	☐	☐	☐
Ulcers.....	☐	☐	☐
Thyroid problems.....	☐	☐	☐
Stroke.....	☐	☐	☐
Glaucoma.....	☐	☐	☐
Hepatitis, jaundice or liver disease.....	☐	☐	☐

	YES	NO	DK
Epilepsy.....	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders.....	☐	☐	☐
If yes, specify:_____			
Sleep disorder.....	☐	☐	☐
Do you snore?.....	☐	☐	☐
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections.....	☐	☐	☐

	YES	NO	DK
Type of infection: _____			
Kidney problems.....	☐	☐	☐
Night sweats.....	☐	☐	☐
Osteoporosis.....	☐	☐	☐
Persistent swollen glands in neck.....	☐	☐	☐
Severe headaches/ migraines.....	☐	☐	☐
Severe or rapid weight loss...	☐	☐	☐
Sexually transmitted disease..	☐	☐	☐
Excessive urination.....	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Print Name of Patient/Legal Guardian: _____ Date: _____

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

For Completion By Dentist

Comments:

_____

_____

_____

_____

_____

_____

Annual Update Form for Current Patients

Email: **Cell #:** **Date**

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable lows. Please note that you will be asked about responses to this questionnaire and there may be additional questions concerning your health. This information is vital and to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: Home Phone: ( ) Work Phone: ( )

Address: City: State: Zip:

Mailing address

Did your Dental insurance change?_____

DENTAL INFORMATION

Has your dental health changed since your last visit?_____

_____

Are you here for routine care?_____

Did you want to address a specific dental need today with your dentist?_____

_____

MEDICAL INFORMATION

ALLERGIES: **Please check "yes" or "no" to any allergies you have.** To all **yes** responses please specify what you are allergic to type and severity of reaction. (Use the back of this form for additional space.)

Yes	No		Yes	No		Yes	No		Yes	No	
❒	❒	Local Anesthetics	❒	❒	Sulfa Drugs	❒	❒	Aspirin	❒	❒	Codeine or other narcotics
❒	❒	Antibiotics	❒	❒	Metal	❒	❒	Iodine	❒	❒	Barbiturates
❒	❒	Hay fever/Seasonal	❒	❒	Animals	❒	❒	Food	❒	❒	Sedatives or sleeping pills
❒	❒	Latex (rubber)	❒	❒	Other						

_____

_____

Do you or have you had Multiple myeloma or metastatic cancer?

Date Treatment began:_____

Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?

Date:_____ If yes, have you had any complications?_____

Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia, Bonivia, Reclast, Prolia) for osteoporosis or Paget's disease? _____

Since 2001, were you treated or are you presently scheduled to begin taking an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease?_____

Has a physician or previous dentists recommended that you take antibiotics prior to your dental treatment?_____

Name of physician or dentist making recommendation_____

Phone number:_____ ( )_____

WOMEN ONLY: Are you pregnant?_____ Are you nursing? _____

Are you using birth control pills or hormone replacement therapy?_____

MEDICAL INFORMATION **Please check yes or no.**

Do you wear contact lenses?_____

Do you use controlled substances (drugs)_____

Do you use tobacco (smoking, snuff, Chew, Bidis)? _____

If so, how interested are you in stopping? *Circle one*: Very / Somewhat / Not interested

Do you drink alcoholic beverages?_____If yes, how much did you drink in the last 24 hours?_____

If yes, how much do you typically drink in a week?_____

Are you now under the care of a physician?_____Physician Name_____

Has there been any change in your health within the past year?_____

If yes, please explain._____

Have you had a serious illness, operation or been hospitalized in that past 2 years?_____

If yes, please explain?_____

Are you taking or have you recently taken any prescription or over the counter medicine?_____

If yes, please list all, including vitamins, natural or herbal preparation on/or dietary supplements:

_____

_____

Please check "yes" or "no" to indicate whether you have had or have any of the following conditions or diseases. If necessary explain yes answers below.

Yes	No		Yes	No		Yes	No		Yes	No	
❒	❒	Artificial Heart Valve	❒	❒	Angina	❒	❒	Arteriosclerosis	❒	❒	Congestive Heart Failure
❒	❒	Congenital heart defect	❒	❒	Damaged heart valve	❒	❒	Heart attack	❒	❒	Heart disease
❒	❒	Heart murmur/MPV	❒	❒	Heart surgery	❒	❒	Low blood pressure	❒	❒	High blood pressure
❒	❒	High cholesterol	❒	❒	**Pacemaker**	❒	❒	Endocarditis	❒	❒	Rheumatic fever
❒	❒	Abnormal bleeding	❒	❒	Anemia/Hemophilia	❒	❒	AIDS/HIV	❒	❒	Arthritis/Rheumatoid Arthritis
❒	❒	Autoimmune disease	❒	❒	Lupus/Erythematosus	❒	❒	Asthma/Bronchitis	❒	❒	Emphysema
❒	❒	Tuberculosis	❒	❒	Cancer/Chemotherapy	❒	❒	Radiation	❒	❒	Excessive urination
❒	❒	Glaucoma	❒	❒	Eating disorder	❒	❒	Ulcer	❒	❒	Gastrointestinal issues
❒	❒	Stomach Problems	❒	❒	Hepatitis/Liver Disease	❒	❒	Kidney problems	❒	❒	Thyroid Problem
❒	❒	Stroke	❒	❒	Seizure	❒	❒	Epilepsy	❒	❒	Osteoporosis
❒	❒	Sleep disorder	❒	❒	Snoring/Sleep apnea	❒	❒	Swollen neck glands	❒	❒	Headaches/Migraines
❒	❒	Recurrent infections	❒	❒	Neurological Disorder	❒	❒	Mental disorder	❒	❒	Night sweats
❒	❒	Weight loss/gain									

_____

_____

Do you have any disease, condition, or problem not listed above that you think your dentist should know about?

Please explain:_____

_____

Reviewed by doctor:_____

Note: Both doctor and patient(s) are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

_____

Signature of Patient/Legal Guardian **Print Name** **Date**

Patient Financial Policy

Thank you for choosing Oasis Dental. We value your confidence in our team, and we are committed to providing high-quality, compassionate dental care in a professional and transparent manner. To ensure mutual understanding and to help us continue delivering excellent service, we have established the following financial policy. This policy outlines our procedures regarding payment, insurance, account management, and appointment attendance so that every patient is fully informed and comfortable with the financial aspects of their care.

Payment for Services

- Patients are ultimately responsible for all treatment fees, regardless of insurance coverage or benefit estimate.
- Payments for all services are due at the time treatment is provided, unless prior arrangements are made with the office.
- We accept cash, debit, most major credit cards and (Care Credit/Financing options).
- Any estimated portion that is not covered by insurance will be due on the date of service. After insurance has paid, the remaining balance is the patient's responsibility.
- If the insurance payment is being sent to the patient, the full cost of treatment will be collected day of service.

Insurance

- An insurance/benefit plan is a contract between the patient and their insurance company.
- It is in the patient's best interest to understand their insurance benefits and limitations.
- As a courtesy, we will perform an initial verification of benefits, but this does not guarantee claim coverage or payment.
- We will file a claim, appeal denials, send pre-determinations when required or requested, as well as follow up on unpaid claims, etc.
- The patient may choose to or be asked to follow up with their dental benefit plan on any questions that they have regarding their estimated benefit, payment for services or denial.

Account Management

- Balances are the responsibility of the patient and due within 30 days of receipt of explanation of benefits.
- 1.5 % interest/service fee is charged on any patient balance over 60 days.

- The patient will receive statements via mail when they have a balance on their account. Phone calls and emails may be used while attempting to collect an outstanding balance. To opt out of a specific form of communication, please make a request in writing.
- If a balance remains unpaid after 120 days, the account may be referred to a collection agency. Additional fees associated with the collections process may be added to the outstanding balance.

Appointment Attendance and Deposit Policy

- To provide the treatment needed, we are setting aside a room, doctor, and team. Making a treatment appointment confirms your availability for the time scheduled. We will provide a reminder to your preferred contact method but want to work with you to schedule at a time you are confident you can keep. A $50 fee is charged for appointments missed or rescheduled within 48 hours of scheduled time.
- A deposit of $100 will be due at the time of scheduling an appointment that is scheduled for over 60 minutes and/ or estimated to have treatment costs at or exceeding $500. This deposit will hold my appointment time and will go toward treatment costs. (initial below)
    - o _____ I will forfeit my deposit if I cancel or reschedule within 48 hours or do not show up for my appointment.
    - o _____ I will be entitled to a refund of my deposit or transfer of my deposit to a new time/day if I have given 48 hours or more notice to cancel or reschedule my appointment.

Patient/Guardian (print): _____

Patient/ Guardian (signature): _____

Coordinator (signature): _____

Date: _____

Informed Consent For Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan, direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. My signature will also serve as a release should I request treatment or radiographs be sent to other attending Doctors in the future.
- Obtain payment from third-party payers in your behalf, ie... dental insurance.
- Conduct normal healthcare operations such as quality assessments and required local/federal certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, financial or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize Oasis Dental and its employees to contact me with information regarding my dental appointments, treatment, billing, health, and services.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Please list any other parties who can have access to your dental information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have been informed and consent to these notices & release information to the above person(s)

_____

Patient Name

_____

Patient/Guardian Signature Date

HIPAA Act

How the Health Insurance Portability and Accountability Act (HIPAA) Will Affect Your Next Dental Visit

The US Department of Health and Human Services has recently issued national health information privacy standards. The Health Insurance Portability and Accountability Act, a federally mandated law known as HIPAA, is designed to:

- provide protection for the privacy ofcertain identifiable healflt data (callel protected health infornatio\ [PHI]),
- ensure health insurance coverage when changing employers, and
- provide standards for facilitating electronic transfers of health care-related information.

While the privacy of your personal PHI will remain confidential, certain aspects of this law will permit disclosures of PHI to facilitate public health activities. The following charts review the types of health dated disclosure allowed under HIPAA.

PHI can be disclosed with your authorization in the following categories.

You may request a limitation or restriction on the disclosure of this information. You have the right to:

- request a restriction or limit of any of the above disclosures used for treatment, payment, or office operations.
- inspect and copy information that may be used to make decisions about your care.
- request an amendment of this information if you feel it is incorrect or incomplete.
- an accounting of disclosures we have made that were not related to treatment, payment, or operations of this office.

These requests must be submitted in writing to the office manager and you will be informed of the specifics that are required.

Treatment - PHI will be used to provide appropriate treatment either by this office or other healthcare providers, diagnostic or fabrication laboratories.

Payment - PHI will be used to facilitate payment for treatment rendered. Your health plan requires this information in order to bill, collect payments, or obtain approval prior to treatment.

Healthcare Operations - In order to ensure all patients receive timely and quality care, PHI will be used to facilitate the daily operations of our practice. These include, but are not limited to:

- clinical/research studies to improve our practice
- appointment reminders by phone calls or mailings
- sign-in sheets used to notify us of your arrival
- posted appointment schedules
- information regarding your treatment options or related benefits and services
- communications with family or friends that are involved in your care or payment for your care

PHI can be disclosed without your authorization in the following categories.

As Required by Law	**Judicial & Administrative Proceedings**	**Oversight** PHI can be disclosed to a health oversight agency as authorized by law for audits, investigations, inspections, and licensure.
Public Health	**Lawsuits & Disputes**	**Workers' Compensation** PHI may be released to workers' compensation or similar programs that provide benefits for work-related injuries or illness.
Public Health Risks	**Law Enforcement**	**Military & Veterans**
Health Research PHI disclosuresa rep ermined when required by federal, state, tribal. or local laws.	**Coroners & Medical Examiners** Release of PHI to officials will occur: in response to a court order, subpoena, discovery request or summons; to identify a suspected fugitive, witness, or missing person; about a victim of crime if unable to obtain permission from the person; to identify a deceased person, determine cause of death, about a death that is believed to be the result of criminal conduct; criminal conduct occurring at the practice; in emergency situations.	**National Security and Intelligence Activities**
Abuse, Neglect, or Domestic Violence PHI can be disclosedto preventa threat to your health and safety or the health and safetv of others.	**Cadaver Organ, Eye, or Tissue Donations** PHI disclosure can be made to organ banks as necessary to facilitate organ or tissue donation and transplantation.	**Protective Services for the President & Others** PHI may be released as authorized by law when requested by military command authorities, federal officials for national security, and protection of the president and other heads of state.

ADAIDM/12-08