Keith A. Combs, DDS, PC

I hereby authorize, as indicated by my signature below, to use and to disclose my Protected Health Information (PHI) for any necessary clinical, financial and insurance purpose, as authorized.

Patient Name _____ **Address** _____

Signature (Patient/Parent/Guardian) _____ **Date** _____

Please check your preferred means of communication:

□ You may contact me at my home telephone_____

□ You may contact me on my mobile telephone_____

□ You may contact me on my work telephone_____

□ You may send me an email at:_____

□ Other_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI)
This is updated yearly, all authorized persons must be listed regardless if on previous form.

1._____Date Added/Removed_____

2._____Date Added/Removed_____

3._____Date Added/Removed_____

4._____Date Added/Removed_____

5._____Date Added/Removed_____

6._____Date Added/Removed_____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign.

□ Communication barriers prohibited obtaining the acknowledgement.

□ An emergency situation prevented us from obtaining the acknowledgement.

□ Other (Please Specify)_____