Kokomo Endodontics

112 E Alto Rd.
Kokomo, IN 46902

Contact Information For Protected Health Information

I, _____, Date of Birth _____, request that the following be used for disclosure of my Protected Health Information (PHI). Protected Health Information includes your name, diagnosis, test results, insurance, and date of services.

You may disclose information to my family members and/or non-family members, listed below.

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail: Phone Number _____
- Other _____
- You may disclose insurance information and Protected Health Information to my dentist.

I have received a copy of the HIPAA Notice of Privacy Practices

Print Name: _____

Signature: _____

(Patient's Signature or Guardian's Signature & relationship if minor)

Date: _____

Emergency Contact: (if different than the person/persons above):

_____