Todd S. Klein, D.D.S.

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(Adult)

I have received a copy of the Notice of Privacy Practices of Todd S. Klein, D.D.S. I hereby authorize, as indicated by my signature below. Todd S. Klein, D.D.S. to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent Form.

_____ _____

Print Patient Name Address

_____

City State Zip

_____ _____

Signature (Patient or Guardian) Date

Please check your preferred means of communication:

___ You may contact me at my home telephone number_____

___ You may contact me on my mobile telephone number _____

___ You may contact me on my work telephone number _____

___ You may send me an email at: _____

___ Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to parents and legal guardians: (If not listed we cannot give information or schedule appointments)

1._____ Date Added/Removed: _____

2. _____ Date Added/Removed: _____

3._____ Date Added/Removed: _____

4. _____Date Added/Removed: _____

5. _____Date Added/Removed: _____