William D. Kenfield DDS LLC
77 Fairview Ave Spencer, IN 47460

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I,___________________________________, Date of Birth_____________, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- o Sensitive Protected Health Information (HIV- related information)
- o You may disclose information to my family members and/or non-family members
  Please list the name, phone number and relationship

NAME__________________________________PHONE NUMBER_____________RELATIONSHIP

____

____

____

____

- o You may leave Protected Health Information on my answering machine/voicemail: Phone Number_______________________
- o You may leave me a text message: Text Phone Number__________________
- o You may email me (unencrypted) for dental appointments:
  Email Address:_____________________________________
- o You may fax me for dental information: Fax Number_____________________
- o Other____

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

(Patient's Signature (or Guardian, if minor)

Date: ____

To e-mail this form to our office, copy this address wkenfield@sbcglobal.net

Click on the envelope near the top of this window, select continue and paste our address on the "to" line. Click send and you are done. You will sign the form in our office.

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:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify)