JOHN F. COMO
DDS/PC

140 LOCKWOOD AVENUE, SUITE 209 NEW ROCHELLE, NY 10801 914-632-1111

TRUSTED CONTACT AUTHORIZATION FORM

I authorize the office of John F. Como, D.D.S., P.C. to contact the individual(s) identified below as my Trusted Contact(s) in the event of a situation described below regarding the dental care or financial account I have with John F. Como, D.D.S., P.C.

If the office of John F. Como, D.D.S., P.C. has questions or concerns about my health, welfare, dental care, or financial concerns they may:

- *Contact my Trusted Contact(s) and disclose information about me, and my account to discuss any questions that may arise.*
- *Confirm with my Trusted Contact(s) my current contact information or health status and/or the identity of any legal guardian, executor, trustee, or holder of a power of attorney.*
- *Communicate with persons who claim legal authority to act for me to determine whether those persons have legal authority over my accounts.*
- *The Trusted Contact must be at least 18 years old.*

I understand that:

_I authorize the office of John F. Como, D.D.S., P.C. to contact my Trusted Contact(s) at any time for any reason without additional consent.

_I may identify multiple contact persons (if needed, use additional copies of this form to list additional Trusted Contacts)

_If multiple contacts are listed, Dr. Como will only contact one of the listed contacts at his discretion.

_John F. Como, D.D.S., P.C. is not required to contact, or attempt to contact, my Trusted Contact person(s).

_I may change or amend my Trusted Contact(s) at any time by providing the office of John F. Como, D.D.S., P.C. a newly-signed Trusted Contact Authorization form, and that this new form will supersede any previous form on file.

_This Authorization is optional and I may withdraw it at any time by notifying the office of John F. Como, D.D.S., P.C. in writing.

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Authorized Trusted Contact Information

Please note that every patient who elects to provide Trusted Contact information must complete and sign his/her own Trusted Contact Authorization form.

_____

Patient Name

_____

Relationship to Patient (e.g., spouse, child, lawyer, accountant, etc.)

Trusted Contact Information

_____

Name of Trusted Contact

_____

Address

_____ _____ _____

City *State/Province* *Zip Code*

_____ _____

Home Phone *Mobile Phone*

_____

Email Address

_____ _____ _____

Patient Signature *Patient Name (Print)* *Date*