PATIENT ACKNOWLEDEMENT OF

THE NOTICE OF PRIVACY PRACTICES

AND CONSENT FOR USE AND DISCLOUSURE OF

PERSONAL HEALTH INFORMATION

___________________________________ ___________________________

(Print Patients Name) (Date)

I, ____, acknowledge that I have received a copy of these offices NOTICE OF PRIVACY PRACTICES or that these offices NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I, ____, consent to the use and disclosure of my personal health information by your office for Treatment, Billing/Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

I authorize the Dental Practice to release records to the following:

____ ______________________

(Name) (Relationship)

____ ______________________

(Name) (Relationship)

____Date______________

(Signature of Patient or Responsible Party)