PATIENT ACKNOWLEDGEMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT FOR NECESSARY USE OF
PERSONAL HEALTH INFORMATION

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Print Patient's Name Date

_____, have received
(Signature of Patient)
a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, _____, consent to the use and
Print Patient's Name
disclosure of my personal health information by your office during treatment. Billing, payment and dental office operations as outlined in the Notice of Privacy Practices