Virginia Family Dental

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
"YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT"

Federal regulations require that Virginia Family Dental Service P.A.'s obtain proof that patients have received the Notice of Privacy Practices. My signature below indicates only that I have received a copy of Virginia Family Dental Service P.A.'s Notice of Privacy Practices, not that I have read it or agree with its contents.

** _____
(SIGNATURE OF PATIENT, RESPONSIBLE PARTY, OR REASON UNABLE TO SIGN & DATE)

CONSENT FOR USE OF DISCLOSURE OF HEALTH INFORMATION

Purpose of consent: By sign this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**** PRINT NAME**: _____

****SIGNATURE**: _____ DATE: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

PLEASE LIST ANY ADDITIONAL PARTIES (GUARDIAN/PARENT/SPOUSE)
WHO ARE ABLE TO REQUEST INFORMATION ON BEHALF OF THE PATIENT

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient:_____