ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES AT CAROLINA FAMILY DENTISTRY

"You may refuse to Sign This Acknowledgement"

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

_____ _____

Signature Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH/DENTAL INFORMATION

Please list the names of all the individuals who can make dental care decisions for _____.

_____ _____

_____ _____

_____ _____

_____ _____

If you would like any other person to have access to you or your child's dental/health information, or if someone other than yourself will be bringing the child to our office for treatment. Please list their name and relationship to the child below.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

I AUTHORIZE THE PERSONS NAMED ABOVE TO BRING MY CHILD TO THEIR DENTAL APPOINTMENTS AND TO MAKE ANY DENTAL TREATMETN AND EMERGENCY CARE DECISIONS NECESSARY.

_____ _____

PARENT /LEGAL GUARDIAN SIGNATURE DATE