ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY & CONSENT TO TREAT

I have had the opportunity to read and consider the contents of the privacy policy. I acknowledge that a copy of Blue Diamond Family Dental's Privacy Policy is available for me or my personal representative. I understand, by signing this form, I am confirming my written permission for the disclosure of my protected health information as described in the Privacy Policy, as warranted.

_____
Please Print Patient Name

_____
Signature Relationship

_____
Date

If this consent is signed by a personal representative/parent on behalf of the patient, complete the following:

Personal Representative's/Parent's Name:_____

Relationship to Patient:_____

I authorize the release of my information to the specified person(s) involved in my care:

_____ Relationship to Patient:_____

_____ Relationship to Patient:_____