wheresmilesgrow

Specializing in dentistry for infants, children & adolescents.

PATIENT: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES AND CONSENT FOR DISCLOSURE FOR TREATMENT, PAYMENT AND OPERATIONS

ACKNOWLEDGMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have, therefore, been advised of how my child's protected healthcare information may be used and disclosed by the office and how I may obtain access to and control of this information. In addition, by signing below, I hereby consent to the use and disclosure of my child's healthcare information for treatment proposed, payment activities and healthcare operations Where Smiles Grow as described in the Notice.

Signature of the Personal Representative or Patient:

_____ Date: _____

Print Name of Personal Representative or Patient (including description of legal authority)

_____

Jason T. Decker DDS
Nancy A. Cavotta, DDS
Jennifer L. Charlesworth, DMD
Kate Carroll, DMD
Daniel C. Caban, DMD

9 Century Hill Dr. • Latham, NY 12110
250 Delaware Ave. • Delmar, NY 12054
ph: 518.785.3911 • f: 518.785.4910