CAPOZZI DENTAL GROUP
FAMILY DENTISTRY

Patient Name: _____ Date of Birth: _____

Acknowledgement of Receipt of Notice of Privacy Practices and Consent

By signing below, I acknowledge that I have been provided a copy of the Capozzi Dental Group Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control this information.

By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment of services given to me, and for the business operations of medical group, its staff, and its business associates.

I grant permission for Capozzi Dental Group to disclose my personal health information, including appointment times, treatment plans and financial information, to the following person(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

❒ I do not grant permission to disclose my information to any personal representative(s)

I understand that this permission will remain in effect unless a written cancellation has been provided to Capozzi Dental Group.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority