VP DENTAL
breathe relax smile

RECEIPT ACKNOWLEDGEMENT

I, ____, or my guardian has received
The Notice of Privacy Policies for Valerie Preston D.D.S., office on date: ________________________.

_____ I do not have any restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations.

Requested restriction: ____
____

Permission to discuss patient health information

I hereby give my permission to the person(s) listed below to receive information about the care of the above named patient:

Name	Relationship
_____________________________________	_______________________________________
_____________________________________	_______________________________________
_____________________________________	_______________________________________

By signing this form, I am consenting to allow Valerie M. Preston, D.D.S. to use and disclose my PHI (personal health information) to carry out Treatment plan options.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Valerie M. Preston, D.D.S. may decline to provide treatment to me.

Print Patients Name: ____________________________________ Date:__________________________

____/____
Signature of Patient or Legal Guardian Print Guardian Name

Legal Guardian Relationship to Patient ____

breathe relax smile *radiate*

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