ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with Smile To Smile Family Dental & Sedation Center, P.A.'s ("Smile-To-Smile") Notice of Privacy Practices ("Notice"):

- It tells me how Smile-To-Smile will use my health information (Including if applicable, information about HIV infection or AIDS, information about substance abuse and treatment, and information about mental health services) for the purposes of my treatment, payment for my treatment, and Smile-To-Smile health care operations.
- The Notice explains in more detail how Smile-To-Smile may use and share my health information for other than treatment, payment, and health care operations.
- Smile-To-Smile will also use and share my health information as required/permitted by law.
- If I am a Smile-To-Smile Employee, or relative of a said employee, receiving dental services, I consent to Smile-To-Smile using and disclosing my treatment records maintained by Smile-To-Smile, for the purposes detailed in Smile-To-Smile Notice of Privacy Practices.

I authorize Smile To Smile Family Dental & Sedation Center, P.A. to release health information identifying me by telephone, email, fax and/or other means to the following:

1. Family Members and Friends- *Please List with Contact Information:*_____
   _____
   _____
   _____
2. Persons or Entities involved in My Care-*Please List with Contact Information:*_____
   _____
   _____
   _____
   _____
3. Other- *Please List*_____
   _____
   _____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed on the 'Notice of Privacy Practices' form.

Please note that when your health information is disclosed, as provided in this authorization, the recipient ofter has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient's Complete Legal Name: _____ (Print)

Patient's DOB: _____ *Patient's SSN:* _____

Patient's Phone Number: _____ *Home;* _____*Cell;* _____ *Other*

Patient's Address: _____

***Patient/Legal Representative Signature**:* _____

Relationship If Not Patient: _____

Source of Authority to Sign This Form (if not patient: _____

Date: _____