Sharon Freeland Harris, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I,_____, have received a copy of this office's Notice of Privacy Practices.

Name of Patient (or parent/guardian if patient is under age 18)

_____

Please print **PATIENT NAME** (self or minor but not parent or guardian)

_____

Please print **PARENT OR GUARDIAN NAME** if patient is under the age of 18

_____

SIGNATURE OF PATIENT (**OR PARENT/GUARDIAN** if patient is under age 18)

_____

Date

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

❒ I, _____ **DO NOT** allow Dr. Sharon Freeland Harris and her staff to discuss my Personal Information.

Name of Patient (or Parent/Guardian if patient is under age 18)

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

Parents: please list below any people who may bring your child to their dental appointment without you

❒ I, _____ allow Dr. Sharon Freeland Harris and her staff to discuss my Personal Information (Financial Account, Dental Information, Appointment Descriptions and Times) with the following people:

Name of Patient (or Parent/Guardian if patient is under age 18)

(please check and print name below if applicable)

- ❒ Husband: _____ (Name)
- ❒ Wife: _____ (Name)
- ❒ Mother: _____ (Name)
- ❒ Father: _____ (Name)
- ❒ Grand parent:_____ (Name)
- ❒ Other:_____ (Name)
- ❒ Other: _____ (Name)

_____ _____

SIGNATURE OF PATIENT (**OR PARENT/GUARDIAN** if patient is under age 18) DATE