MINEOLA DENTAL CARE PC

Dr. Asha Joshua DDS & Dr. Rachel Thomas DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Notice of Practices before you decide whether to sign this consent. We encourage you to read it carefully and completely before signing this consent.

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.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted in writing.

I____, have received a copy of this Office's Notice of Privacy Practices.

Signature___________________________________Date________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____

Relationship to Patient:____