

HIPAA-Consent Form for Patients  
SMILE DESIGN DENTAL GROUP

**Acknowledgment of Receipt of Notice of Privacy Policies  
And Consent for Disclosure for Treatment, Payment and Operations**

ACKNOWLEDGMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of the Patient or Personal Representative

\_\_\_\_\_

Print Name of Patient or Personal Representative \_\_\_\_\_

Description of legal authority \_\_\_\_\_

Date \_\_\_\_\_