

# Acknowledgement of Receipt of Notice of Privacy Policies

I, \_\_\_\_\_, have received a copy of  
Pacific Coast Dentistry's Notice of Privacy Policies.

\_\_\_\_\_  
Name (print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Consent for Use and Disclosure of Personal Health Information

This form authorizes us to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

For questions concerning our Notice of Privacy Policies, please contact:

Office Administrator, You may reach (*him/her*) by telephone @ (805) 226-8126

### Patient's Consent

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I, \_\_\_\_\_, have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed