Joseph A. Silvaggio, DMD, PC
SILVAGGIO ENDODONTICS EASTON ENDODONTICS, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Date _____

This acknowledgement of notice and consent authorizes Joseph A. Silvaggio, DMD, PC to use and disclose health information about you and your treatment, payment, and healthcare operations purposes. This practice has a "Notice of Privacy Practices," which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. ***Please ask at the front desk if you desire to read or obtain the full privacy notice.***

I, (print name) _____, am aware of and/or received a copy of this practice's "Notice of Privacy Practices" and authorize them to use and disclose health information for treatment, payment, and healthcare operations purposes consistent with its "Notice of Privacy Practices."

_____

Signature of Patient *(or parent/guardian if patient is a minor)*

_____ _____

Printed Name of Minor Patient **Relationship to Patient**

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Please fill in the **EMERGENCY CONTACT PERSON.** Also fill in **ALL NAMES OF THOSE WITH WHOM WE CAN DISCUSS YOUR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.** It is not necessary to include your dentist/referring dentist, as it is understood that he/she would be included to receive your treatment, payment, or healthcare operations information.

Emergency Contact	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number
Responsible Party	Relationship to Patient	Phone Number

AT WHAT TELEPHONE NUMBERS ARE WE ABLE TO CALL YOU OR LEAVE A MESSAGE FOR YOU?

PREFERRED TELEPHONE NUMBER_____ **INDICATE** CELL / WK / HM

2ND PREFERRED NUMBER _____ **INDICATE** CELL / WK / HM

3RD PREFERRED NUMBER _____ **INDICATE** CELL / WK / HM