

**Schwartz Family Dentistry  
833 Union Street  
Schenectady, NY 12308**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT TO USE AND DISCLOURE FOR TREATMENT, PAYMENT,  
AND OPERATIONS PURPOSES**

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 this 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 this office.

I hereby authorize the following person(s) to have access to information covered under the privacy practices regarding myself. Please include their relationship to you and their contact information.

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_