

**SCHWARTZ FAMILY DENTISTRY
833 UNION STREET
SCHENECTADY, NY 12308
(518) 374-1935**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
CONSENT TO USE AND DISCLOSURE FOR THE 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.

Signature: _____ Date: _____