HORN DMD & CAYE DDS LLC
599 MAIN STREET
MANCHESTER, CT 06040

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

&

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name: ____

Address: Street: ______________________________ Town: ____________________

Telephone: Home ____________________ Work ____________________ Cell ____________________

E-mail: ________________________ **Please Circle the Best Number to Confirm Appointments**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: ____________________________ Date: ________________________

If this Consent is signed by a Parent/Guardian on behalf of the patient, please complete the following:

Parent/Guardian's Name: ______________________________

Relationship to Patient: ______________________________