Acknowledgement of Receipt

I acknowledge that I received a copy of Andrew G. Gilfillan, DDS, PLLC Notice of Privacy Policies. I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

____ Date__________________
Patient Name

____
Patient/Parent/Guardian Signature (Responsible Party)

Additional people to have access to information

I would like to give the following people access to personal health information (such as spouse or family)

Name____Relation_____________________________

Name____Relation_____________________________