BENNINGTON DENTAL CENTER

Family and Cosmetic Dentistry

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATAION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges feceipt of a copy of the currently effective Notice of Privacy Practices for this healthcraft facility. A copy of this signing dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE. Please print name of Patient Please print name of Patient print name of Patient Please print name of Patient Please	Date:	
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