Deerfield Family Dental

ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, hereby authorize Deerfield Family Dental, Inc., Dr. Antonio Festa and Dr. Alain Pouleriguen (the "Practice") to disclose my entire medical records (or the medical record of _____) in accordance with the Deerfield Family Dental Inc. Notice of Privacy Practices for treatment, payment and healthcare operations purposes. I have reviewed the Notice of Privacy Practices, been given the opportunity to ask questions about it, understand and do hereby agree to the terms. I understand that the Practice may amend its Notice at any time and that I am entitled to receive a current copy of the Notice of Privacy Practices by requesting on at the front desk, or by contacting the Practice's privacy officer, Donna M. DiChiara, Esquire at 954.725.3717.

I understand that I can revoke this Consent in writing at any time, except to the extent the Practice has already taken action relying upon it.

By: _____(Patient or representative's signature

_____(Print name)

Date:_____

FOR OFFICE USE ONLY: