Frederick J. Norfolk, DMD, LLC
116 Water Street
Milford, MA 01757

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse To Sign This Acknowledgement**

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

May we call you at home regarding scheduling matters, etc.?	____yes	____no
May we call you at work regarding scheduling matters, etc.?	____yes	____no
May we call your cell phone to confirm appointments?	____yes	____no
May we send you a text message to confirm appointments?	____yes	____no
May we send you an email to confirm appointments?	____yes	____no

_____home phone number

_____cell phone number

_____work phone number

_____email address

CONSENT TO DISCLOSE HEALTH INFORMATION

CONSENT TO SHARE MY PERSONAL HEALTH INFORMATION (age 18 and over)

I consent to the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. You may speak with the following people regarding my dental services, payments, account and insurance information:

_____	_____	_____
Name	Relationship	Date
_____	_____	
Name	Relationship	Date

I understand that this consent to disclose may be revoked by me at any time by giving written notice of revocation to this office.