

**NORTH BUFFALO DENTAL GROUP**

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES AND CONSENT TO  
USE AND DISCLOSURE FOR TREATMENT,  
PAYMENT AND OPERATIONS PURPOSES**

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office.

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Signature of Patient or Personal Representative

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Print Name of Patient or Personal Rep. (including description of legal authority)

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Date