Michael J. Maloney, D.D.S., P.C.

216 Troy Schenectady Road
Latham, NY 12110-3425

Telephone: (518) 782-9015
MaloneyDDS@gmail.com

HIPAA – Consent Form for Patients

Acknowledgement of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations.

ACKNOWLEDGEMENT AND CONSENT

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 including the mailing of appointment cards, reminding me of my next appointment date and time, email and/or text messages as authorized by you as described in the Notice.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Relationship

FOR PATIENTS 18 YEARS OF AGE AND OLDER

I authorize release of all my treatment details and information to:

Name **Relationship**

_____ _____

_____ _____

This authorization will remain in effect until you contact us to cancel it.