

ANASTASIA DENTAL ASSOCIATES

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**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND
CONSENT OF RELEASE OF HEALTH INFORMATION**

You May Refuse to Sign This Acknowledgment

I acknowledge that I have read a copy of the currently effective Notice of Privacy Practices for Anastasia Dental Associates. I also understand that the purpose of the Notice of Privacy Practices is to inform me that no personal information will be released without my consent and that I do consent to the release of my personal information to insurance companies and other doctors, dentists, and other personnel in the normal course of my treatment and only as necessary as detailed in the Notice of Privacy Practices.

Signature

Date