Acknowledgement of Receipt of
Notice of Privacy Policies

This form authorizes Dr. Judson Valstad, DMD, Inc., to use and disclose your personal health information (PHI) for the purpose of healthcare operations, treatment, and payment activities as explained in our Notice of Privacy Policies.

Before signing, please read our Notification of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI.

I, (print patient's name)_____________________________________, have received a copy of Dr. Valstad's Notice or Privacy Policies.

Signature____Date__________

If this consent is signed by someone other than the patient, please complete the following:

Parent/Guardian______________________________________ Date___________