



Cara A. Coleman, D.M.D.

1 Overlook Drive, Suite A3

Amherst, NH 03031

(603)673-4102

Acknowledgement of Review of Financial Agreement and Authorization for Use or Disclosure of Dental/Health Information and Receipt of Privacy Practice Notice:

I, _____, acknowledge that I have reviewed and understand the Financial Agreement and Authorization for Use and Disclosure of Dental/Health Information. I have also received a Notice of Privacy Practices from Coleman Family Dental Care.

(Signature)

(Date)

If a personal representative signs this authorization on behalf of the individual, please complete the following:

Personal Representative's Name

Relationship to Individual