Chesterfield
Dental Associates

Marc Sattovia, D.M.D., F.I.C.O.I.
Amanda D. Coyle, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(Complete Policy is Available in our Office)

I, _____, have received a copy of
(Please print patient's name)

Chesterfield Dental Associates Notice of Privacy Practices.

I wish to grant _____ permission to:
(Print name and indicate relationship)

_____ discuss my care and schedule any needed appointments with **NO RESTRICTIONS**

_____ discuss my care and schedule any needed appointments (**NO DENTAL RECORD ACCESS**)

_____ schedule any needed appointments only (**APPOINTMENT ONLY ACCESS**)

_____ **I DO NOT GRANT ANY ACCESS TO ANYONE**

I understand that I can withdraw consent at any time by providing Chesterfield Dental Associates with a written consent indicating the changes in access.

_____ _____
Patient Signature (or Legal Guardian) Date

16100 Chesterfield Parkway West Suite 320 Chesterfield, MO 63017-4817 (636) 532-3208 Fax: (636) 532-1371
www.chesterfielddentalassoc.com