

**Dr. Whitney Frank DDS
801 East Medical Court
Post Falls, ID 83854**

Consent of Privacy Practices

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent
To use and disclose my protected health care information for the purpose of
treatment, payment and health operations as described in the Privacy Notice.

PRINT NAME – Patient/Legal Guardian if under the age of 18

SIGNATURE- Patient/Legal Guardian if under the age of 18

SIGNATURE- Authorized Facility