

Patient's name \_\_\_\_\_

**1. HIPPA CONSENT:**

I have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**2. EDUCATIONAL CONSENT:**

I do hereby consent for Dr. William Raineri and Dr. Charles DiCosimo III to utilize any of the diagnostic data in his teaching seminars, in his written texts and scientific publications. This data will be presented to other medical and dental practitioners solely to help further their professional education and expertise. I have further been informed that absolutely no personal, social or financial information will be divulged at any time as this information is strictly confidential.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**3. TECHNOLOGY CONSENT:**

I do hereby consent for Dr. William Raineri and Dr. Charles DiCosimo III to utilize any photos for in-office use, for our office website, social media pages or through e-mail. I have also been informed that absolutely no personal or financial information will be divulged at any time as this information is strictly confidential.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-mail address  
(Also used for confirming appointments)

(You may refuse to sign any or all of these acknowledgements.)

**Dr. William A. Raineri and Dr. Charles J. DiCosimo III**