

## ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Roosevelt Dental Center of Skagit County. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Roosevelt Dental Center of Skagit County reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

### ADDITIONAL DISCLOSURE AUTHORIZATION

*In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)*

Spouse only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OR</b>		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (i.e. Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other:	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**Name of patient (please print):** \_\_\_\_\_

**Patient signature:** \_\_\_\_\_

**Patient's personal representative: (Please Print):** \_\_\_\_\_

**Personal Rep's signature:** \_\_\_\_\_

**Representative's Phone Number:** \_\_\_\_\_

**Date:** \_\_\_\_\_

### OFFICE USE ONLY BELOW THIS LINE

#### Acknowledgement Not Obtained

<b>Provided Prior to Treatment?</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Date Statement Provided:</b>
<b>Reason for not obtaining patient signature</b>	<input type="checkbox"/>	<b>Needed more time to review Statement</b>	
	<input type="checkbox"/>	<b>Wanted to consult another person before signing</b>	
	<input type="checkbox"/>	<b>Physically unable to sign</b>	
	<input type="checkbox"/>	<b>No reason offered</b>	
	<input type="checkbox"/>	<b>Other:</b>	