TUMMARELLO & PANDAK, DDS PC
11208 Waples Mill Road, Suite 101
Fairfax, VA 22030
(703) 691-1511

Acknowledgement of Receipt of Statement of HIPAA Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Tummarello & Pandak, DDS PC. 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.

Tummarello & Pandak, DDS PC reserves the right to change the privacy practices that are 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 to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information, dental appointments and billing to the person(s) indicated below.

- Any Member of my immediate family **Y___ N___**
- Spouse Only **Y___ N___**
- Other (please provide below name and number) **Y___ N___**

  Name: _____

  Phone:_____

Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

I consent to receive calls and text messages related to my protected healthcare and other services. I also agree that the practice may communicate with me electronically at the following address:

Cell Phone: _____ **Home Phone:** _____ **E-Mail:** _____
(or leave message on voicemail) **(or leave message on answering machine)**

Acknowledgement of Receipt of Notice of Privacy Practices

_____ X_____ _____
Print: Name of Patient/Parent or Legal Guardian **Signature of Patient/Parent or Legal Guardian*** **Date**

***If signed by other than patient, specify relationship to patient:** _____

Office Use Only
Record of Acknowledgement

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Patient/Parent or Legal Guardian refused to sign form.

_____ Other Reason_____

Office Staff Signature:_____ Date:_____