FAMILY DENTISTY

11208 WAPLES MILL RD., SUITE 101
FAIRFAX, VA 22030
(703)691-1511

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 Family Dentistry. 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.

Family Dentistry 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 DISCOSURE 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 to the persons indicated below**.**

ANY MEMBER OF MY IMMEDIATE FAMILY	YES	NO
SPOUSE ONLY	YES	NO
OTHER (*please specify)*	YES	NO

_____ _____

Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____

Date Description of Personal Representative

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained	
Provided Prior to Treatment?	YES NO
Date Provided:	___/___/___
Reason for Denial:	___ Needed more time to review statement of privacy practices
	___ Wanted to consult with another person before signing
	___ Unable to sign
	___ Reason not given
	___ Other (explain):