promise
ESTHETIC FAMILY DENTISTRY

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy for the offices of Promise Esthetic 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.

Promise Esthetic 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.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosures 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's Authority**

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):_____

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