

**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 Raymond Hsu, DDS. 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.

Raymond Hsu, DDS 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 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) \_\_\_\_\_