ACKNOWLEDGMENT 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 Sunrise Dental of Bellevue. 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 service, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Sunrise Dental of Bellevue 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 indicated "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only ☐ YES ☐ NO

Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses) ☐ YES ☐ NO

Any Member of my extended family: (i.e. Parents, Grandchildren). ☐ YES ☐ NO

OTHER:_____ ☐ YES ☐ NO

Name of patient (please print):_____

Patient signature (if 18+ years of age): _____

Patient's personal representative (please print): _____

Personal Representative's signature:_____

Representative's Phone Number: _____ Date: _____