Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of West Seattle Endodontics, LLC. 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.

West Seattle Endodontics, LLC 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 Health Information to the person(s) identified below. I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected health information cannot be shared with anyone unless otherwise allowed by HIPAA rules.

Spouse / Partner Only	YES	NO
OR		
Any Member of my immediate family: (Spouse / Partner / Children)	YES	NO
Any Member of my extended family: (Parents / Grandparents)	YES	NO
Other: ____	YES	NO

Name of Patient (Please Print):____

Patient (or Parent / Guardian) Signature:______________________________________

Date:_________________________

OFFICE USE ONLY BELOW THIS LINE

ACKNOWLEDGEMENT NOT OBTAINED

Provided Prior to Treatment? YES NO

Date Statement Provided:________________

Reason for not obtaining patient signature	Needed more time to review Statement
	Wanted to consult another person before signing
	Physically unable to sign
	No reason given
	Other:____________________________________