

Troy Family Dental

1516 Hudson Street, Suite 101
Longview, Washington 98632
360-423-5240

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 Troy Family Dental. 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 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.

Troy Family Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at 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): _____