ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

Kirkland Dental Partners

13718 100th Ave NE, Kirkland, WA 98034 (425) 822-0505

I acknowledge that I have received a copy of the Statement of Privacy Practices for Kirkland Dental Partners. 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.

Kirkland Dental Partners 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 POLICY.		
		WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING.		
		UNABLE TO SIGN.		
		REASON NOT GIVEN.		
		OTHER (EXPLAIN):		