Acknowledgement of Receipt of Notice of Privacy Practices

Advanced Pediatric Dentistry
1060 W ELM AVE #115
Hermiston, OR. 97838
541-289-5433 ▪ www.hermistonkidsdentist.com

I acknowledge that I have been informed of, reviewed, and given the opportunity to secure a copy of the Notice of Privacy Practices. The Notice of Privacy Practices explains how my protected health information may be used and disclosed for purposes of my treatment, payment for services, and the performance of our office health care operations. It also outlines my rights, as well as the responsibilities, and duties of this office with respect to my protected health information. I understand that I may request a copy of the full Notice of Privacy Practices. This office reserves the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we obtain.

ADDITIONAL DISCLOSURE AUTHORIZATION
I authorize the disclosure of my Protected Health Information to the following individuals to receive information, discuss my health records, and receive voice, email and/or text messages.
Name: Relationship:
Name: Relationship:
Name: Relationship:

Name: Relationship:

Patient Signature (if 18 years or older): Date:

Name of Patient (Please Print):
Legal Guardian (Please Print): Relationship:
Legal Guardian Signature: Date:
Telephone Number:

OFFICE USE ONLY BELOW THIS LINE

ACKNOWLEDGEMENT NOT OBTAINED	
Reason for not obtaining patient signature:	□ Declined to sign
	□ An emergency situation prevented us from obtaining acknowledgement
	□ Physically unable to sign

	□ No reason offered
	□ Other (Please specify):
	Employee Signature: