value dental

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Value 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 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. Value Dental 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.

May we phone, email or send a text to you to confirm your appointments? ☐ **Yes** ☐ **No**

May we leave a message on your answering machine at home or on your cellphone? ☐ **Yes** ☐ **No**

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**

_____ _____

Printed Name of Patient Date

_____ _____

Signature of patient or guardian Relationship to Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other – Please specify_____