DANE DENTAL LLC

ACKNOWLEDGEMENT RECEPIT NOTICE OF HIPAA PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for Dane Dental. The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations.

The Notice of Privacy Practices also describes my rights and the responsibilities and duties of Dane Dental with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility. Dane Dental reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice 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/PARTNER ONLY _____ ☐ YES ☐ NO

OTHER (PLEASE SPECIFY) _____ ☐ YES ☐ NO

I understand that I have the right to terminate disclosure to have above person(s) at any time with a written request.

MY SIGNATURE BELOW ACKNOWLEDGES I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. ALL OF MY QUESTIONS HAVE BEEN ANSWERED AND I UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS ACKNOWLEDGEMENT AND/OR CHANGES IN THE ADDITIONAL DICLOSURE AUTHORITY AT ANY TIME

PRINT PATIENT'S NAME _____ DATE _____

PATIENT/GUARDIAN'S SIGNATURE _____