

Uptown Dental Clinic

Port Townsend, WA 98368

ACKNOWLEDGEMENT OF RECEIPT – NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Uptown Dental Clinic. The Notice 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 Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Uptown Dental Clinic reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA.)

Spouse Only: <input type="checkbox"/> YES <input type="checkbox"/> NO	Spouse's Name:
Partner Only: <input type="checkbox"/> YES <input type="checkbox"/> NO	Partner's Name:
Any member of my immediate family (Spouse, Children, Children's Spouses) <input type="checkbox"/> YES <input type="checkbox"/> NO	
Any member of my extended family (Parents, Grandchildren) <input type="checkbox"/> YES <input type="checkbox"/> NO	
Patient's Personal Representative: <input type="checkbox"/> YES <input type="checkbox"/> NO	
Representative Name:	Telephone No:
Representative's Signature:	
OTHER: <input type="checkbox"/> YES	Name:
	Tele #:
Patient's Name: (Please Print)	
Patient's Signature	

Acknowledgement Not Obtained			
Provided Prior to Treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date Provided:
Reason for not obtaining patient signature:	<input type="checkbox"/>	Needed more time	Wanted to consult another person
	<input type="checkbox"/>	Physically unable to sign	<input type="checkbox"/> No reason offered
	<input type="checkbox"/>	Other:	
	<input type="checkbox"/>		