Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Jeffrey D. Pruiett, DMD. 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.

Stacey C. Sype 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 Healthcare 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**	☐	**DATE STATEMENT PROVIDED:**_____	
	NO	☐		
REASON FOR NOT OBTAINING SIGNATURE			☐	**NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES**
			☐	**WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING STATEMENT**
			☐	**UNABLE TO SIGN**
			☐	**REASON NOT GIVEN**
			OTHER:	

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