KIRKLAND
FAMILY DENTISTRY

1715 Market Street, Suite 104, Kirkland, WA 98033 425.822.0435

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 Benjamin J. Greene, DDS and Jonathan D. Everett, DDS. 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.

Jonathan D. Everett, DDS and Benjamin J. Greene, DDS reserve the right to change 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 a copy mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby authorize disclosure of my protected health care information to the person(s) listed 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

FOR OFFICE USE ONLY

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided Prior to Treatment: ○ YES ○ NO Date Provided: _____/_____/_____

REASON FOR DENIAL

○ Needed more time to review Statement of Privacy Practices ○ Wanted to consult with another person before signing
○ Unable to sign ○ Reason not given ○ Other (Please Explain) _____