

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices of the office of Arthur M. Strauss, D.D.S. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, my 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.

Arthur M. Strauss, D.D.S. 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 sent 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 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 _____

Messages pertaining to my dental appointments may continue to be left on voice mail.

- . HOME YES___ NO _____
- . WORK YES___ NO _____

NAME OF PATIENT (Print)

SIGNATURE OF PATIENT or Personal Representative

DATE