Scott W.W. Steedman, D.D.S., M.P.H., P.S.

ACKNOWLEDGEMENT OF RECEIPT FOR STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Scott W.W. Steedman. The statement of Privacy Practices describes the types and 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 responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Scott W.W. Steedman has the right to change the privacy practice that is 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 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

_____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

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 (Explain): _____

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