ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have been offered or received a copy of the Statement of Privacy Practices for the office of Dr. Ridl, 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, payment for services, or in the performance of the office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Ridl, 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 mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I herby specifically authorize disclosure of my protected health care information to the persons below.	
ANY MEMBER OF MY IMMEDIATE FAMILY_____	YES__NO____
SPOUSE ONLY_____	YES__NO____
OTHER *(Please Specify)*_____	YES__NO____

_____ _____

SIGNATURE OR NAME OF PATIENT **DATE**

_____

SIGNATURE OF PARENT OR CAREGIVER

OFFICE USE ONLY BELOW THIS LINE

Unable to Sign _____

Reason for Denial_____

Reason not Given_____

Other:_____