Dr. Charles Wallace, DDS, PS
Dr. Pamela Solhaug, DDS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Dr. Wallace & Dr. Solhaug. The Notice 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's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility. Dr. Wallace & Dr. Solhaug reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. Please check 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:
- □ Need more time to review Notice of Privacy Practices
- □ Wanted to consult with another person, before signing
- □ Unable to sign
- □ Reason not given
- □ Other (explain):

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