

**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 Wagner Family Dentistry. 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.

Wagner Family Dentistry reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
<i>In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)</i>		
Spouse only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained		
Provided Prior to Treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	Date Statement Provided: _____	
Reason for not obtaining patient signature	<input type="checkbox"/>	Needed more time to review Statement
	<input type="checkbox"/>	Wanted to consult another person before signing
	<input type="checkbox"/>	Physically unable to sign
	<input type="checkbox"/>	No reason offered
	<input type="checkbox"/>	Other: