



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 Gainesville Dental Associates, PLLC. 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 of 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.

Gainesville Dental Associates 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 hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SPOUSE ONLY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OTHER (PLEASE SPECIFY)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Please state reason below, if you are not signing consent for privacy.
