

Alyce O'Brien & Jack Batjer, D.D.S., P.L.L.C.
1919 North Pearl Street, Suite A1
Tacoma, Washington 98406
(253) 756-2100

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the offices of Alyce O'Brien & Jack Batjer, D.D.S., P.L.L.C. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of 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 this facility.

Alyce O'Brien & Jack Batjer, D.D.S. 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.

Any member of my immediate family
Spouse only
Other (Please specify) _____

YES ___ NO ___
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 notices of privacy practices _____

Wanted to consult with another person before signing _____

Unable to sign _____

Reason Not Given or Other _____