Pediatric Dental Associates
6015 100th Street SW
Lakewood, Washington 98499
253-582-2626

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I may request a copy of the Statement of Privacy Practices for the office of Pediatric Dental Associates. 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.

Pediatric 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 disclosure described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my child's protected health care information to the persons indicated below.				
SPOUSE	☐	**YES**	☐	**NO**
OTHER ***(PLEASE SPECIFY):***				

Name of Patient

Parent-Guardian/Please Print

Signature of Parent-Guardian

Date

Relationship

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained				
PROVIDED PRIOR TO TREATMENT:	☐	**YES**	☐ **NO**	
DATE PROVIDED:				
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.		
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.		
	☐	UNABLE TO SIGN.		
	☐	REASON NOT GIVEN.		
	☐	OTHER (EXPLAIN):		