Gundersen Dental Care
115 Cleveland Avenue SE
Tumwater, Washington 98501
360-352-2781

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 Gundersen Dental Care. 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 is also posted in the facility.

Gundersen Dental Care 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.

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 ○ 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

OFFICAL USE ONLY BELOW THIS LINE

Record of Acknowledgment not obtained

Provided Prior To Treatment? ○ **YES / NO** ○
Date Provided:
Reason for Denial:
___ ○ Needed more time to review notice of privacy practices
___ ○ Wanted to consult with another person, before signing
___ ○ Unable to sign
___ ○ Reason not given
___ ○ Other (explain):