GILBREATH DENTAL

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Gilbreath Dental. 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, 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.

Gilbreath Dental reserves the right to change the privacy currently described in the Statement of Privacy Practices. If the privacy changes, 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.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communications barriers prohibited obtaining the acknowledgement
_____ An emergency situation prevented us from obtaining acknowledgement
_____ Other (Please Specify):

Patient Printed Name: _____ Date:_____

Patient Signature: _____